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Public Health Governance and Primary Care Delivery: a Triangulated Study

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Glossary of terms/abbreviations

APMS	Alternative Provider Medical Services
AOP	Annual operating plan
CAA	Comprehensive area assessment
CBA	Cost-benefit analysis
CCA	Cost-consequence analysis
CEA	Cost-effectiveness analysis
CUA	Cost-utility analysis
CQC	Care Quality Commission
CQUIN	Commissioning for quality and innovation
CSP	Commissioning and strategic plan
DALY	Disability-adjusted life year
DH	Department of Health
DPH	Director of Public Health
DS	Director of Strategy
FD	Financial Director
FOI	Freedom of information
FUR	Freed up resources
GMS	General Medical Services
GO	Government Office
JSNA	Joint strategic needs assessment
LAA	Local area agreement
LES	Local enhanced service
LINK	Local Involvement Network

LSP	Local Strategic Partnership
NCHOD	National Centre for Health Outcomes Development
NICE	National Institute for Health and Clinical Excellence
NIS	National indicator set
NED	Non Executive Director
OSC	Overview and Scrutiny Committee
PbR	Payment by results
PBC	Practice-based commissioning
PBMA	Programme budgeting and marginal analysis
PCT	Primary Care Trust
PEC	Professional Executive Committee
PMS	Personal Medical Services: a locally agreed alternative to the General Medical Services (GMS) contract
PHS	Preventative health spend
PPIF	Patient and Public Involvement Forum
PSA	Public Service Agreement
QALY	Quality-adjusted life year
QIPP	Quality, innovation, productivity and prevention
QOF	Quality and outcomes framework
QQIP	Quest for quality and improved performance
RCT	Randomised controlled trial
SHA	Strategic Health Authority
SPMS	Specialist Provider Medical Services
SPOT	Spend and outcome tool
VCS	Voluntary and Community Sector
WCC	World Class Commissioning

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Contributions of authors

Linda Marks, Senior Research Fellow, Policy Analysis, is PI for the study and responsible for conception of the project, project coordination, study design and preparation of the final report. She carried out a scoping study of public

health governance, an analysis of second phase interviews, and contributed to the analysis of focus groups.

Sally Cave, Research Associate, carried out a mapping study and analysis of the focus groups. She was responsible for conducting and analysing interviews in the first phase of fieldwork and for documentary analysis in the case study sites.

David J. Hunter, CI, Professor of Health Policy and Management, contributed to the conception of the project, focus groups, focus group analysis, and commented on project outputs.

James Mason, CI, Professor of Health Economics, conducted the review of economic evaluation of public health interventions, contributed to the review of economic theory and incentives for commissioning and the review of prioritisation tools.

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Anne Mason, Research Fellow, Health Economics, conducted the review of economic theory and incentives for commissioning and contributed to the review of prioritisation tools.

Helen Weatherly, Research Fellow, Health Economics, conducted the review of prioritisation tools and contributed to the review of economic theory and incentives for commissioning.

Kate Melvin, Independent Consultant, carried out all second phase interviews, a number of first phase interviews and contributed to their analysis.

Executive summary

Background

Government commitments to improving health and addressing inequalities are reflected in a range of policies, standards and targets, but shifting the focus of the NHS towards prevention has proved difficult to achieve. Much depends on how commissioners interpret and prioritise health and well being and the extent to which a preventive ethos is reflected throughout the commissioning cycle. Governance arrangements are intended to promote effective decision-making and reflect underlying principles and values. However governance arrangements are complex, conflicting incentives are layered into the health care system and there are many competing priorities. This study explored the extent to which governance structures and incentive arrangements acted as enablers or barriers to a preventive agenda.

Aims

The aim of the study was to identify the impact of governance structures and incentive arrangements on commissioning for health improvement and on the health improvement activities of practices. This raised specific research questions. What is the impact of performance management regimes? How are commissioners deploying their contractual flexibilities or using incentives to promote health and well being? How is public involvement in commissioning being achieved and to what extent is prevention prioritised? We also explored the concept of stewardship as an underlying principle of governance.

Methods

In order to provide a conceptual framework and inform fieldwork we mapped elements of performance management regimes, scoped approaches to governance, assessed prioritisation tools and reviewed economic theory on incentives of relevance to commissioners. Public health governance was discussed in three focus groups, one with national stakeholders and two with regional stakeholders. Fieldwork involved 99 semi-structured interviews in ten purposively selected case study sites across England. Interviewees included PCT Chief Executives and Executive Directors, practice-based commissioning (PBC) leads, members of the voluntary and community sector (VCS), and Chairs of Local Involvement Networks (LINKs) and of Overview and Scrutiny Committees for Health. An on-line survey of PCTs provided a national context for case study findings.

Results

Commissioning organisations differ in the extent to which they reflect a preventive ethos. Commissioning for health and well being was often viewed as synonymous with commissioning, spanning prevention and hospital care. Practice-based commissioners were often poorly integrated with the commissioning cycle and few had influenced their local Joint Strategic Needs Assessments (JSNAs).

There are different approaches to governance, including procedures for managing risk within organisations, participatory governance and governance between organisations. Leadership for health and well being involved negotiating these arrangements and encouraging a public health perspective. Many commissioner interviewees focused on processes of governance within PCTs and performance management regimes were also largely geared to single organisational performance. Performance management of joint targets by Strategic Health Authorities and Government Offices was often poorly integrated. There was a hierarchy of targets and health improvement targets were not always prioritised.

Changes in regulatory arrangements through the Comprehensive Area Assessment encouraged a shift towards cross-agency governance which better reflected the breadth of a public health system. However, partnership governance arrangements for a preventive agenda required development. Separate themed partnerships under Local Strategic Partnerships for areas such as safety, environment or economic development, tended to fragment the health and well being agenda.

Policy and commissioning guidance emphasises public accountability through patient and public involvement throughout the commissioning cycle. Initiatives in PCTs ranged from formal involvement to large stakeholder events. In practice, engagement often fell short of an influential role in decision-making anticipated by members of the VCS and potential synergies between VCS activities and partnership strategies were not adequately exploited. Public involvement in PBC was limited. While LINKs could provide a route for engaging with local communities, commissioners needed to clarify their role in formal decision-making structures. Scrutiny committees were typically focused on health care, often responding to public concern. Commissioners considered it difficult to engage the public in a longer term health and well being agenda and public interest was skewed towards health care services.

Commissioners can incentivise provider performance through contracts, local reward schemes and enhancements to the Quality and Outcomes Framework (QOF). They can also reward behaviour change through individual incentives. Local Enhanced Services, a locally agreed element of the GMS contract, were the most widely cited incentive for the provision of preventive services. These were viewed as an effective and flexible approach to meeting targets and addressing gaps in the QOF. However, they were also optional and piecemeal, vulnerable in times of economic

downturn and had the potential to increase inequalities. Contract specifications and performance management were often weak.

Other incentives included resources associated with Spearhead status or Freed up Resources (FUR) for successful demand management through PBC. Additional Spearhead resources formed part of baseline allocations, and seemed to have exerted little independent influence. FUR were contingent on the financial situation of PCTs and annual funding made it difficult for practices to demonstrate success. Some PCTs had introduced recurrent funding or pooling of resources in order to address this. There were shifts towards more rigorous performance management of primary care, deployment of contractual flexibilities, and clustering of LESs, which encouraged a more collaborative approach across practices. There were also attempts to devise local budgets which incentivised outcomes rather than activity. Commissioners considered it important to collaborate and not rely on transactional approaches.

Prioritising investment is a key task for commissioners. Methods for prioritising investment within the NHS or across partnerships were under-developed. Historically, growth money had been used for investing in health promotion. Interviewees emphasised the importance of demonstrating the business case for prevention, although few were optimistic that preventive services would be protected in a period of economic downturn and much would depend on how acute sector demand was managed. However, economic stringency could also spur radical restructuring and whole system investment. Although monitoring preventative health spend could clarify changes in the balance of investment, commissioners considered it difficult to measure.

Programme budgeting was commonly used to investigate outliers in terms of costs, but there were concerns over the timeliness and quality of data. Many were developing their own prioritisation matrices but a comparative analysis of tools available demonstrates that tools vary in the extent to which they assess inter-sectoral aspects, changes over time, or equity.

Conclusions

The extent to which a public health ethos is embedded in the commissioning cycle is reflected in the use of incentives and contractual flexibilities for preventive services, methods for prioritising investment in health and well being and the emphasis accorded to partnership governance. Our study shows variation in almost every aspect of commissioning practice, leading to the following recommendations.

1. Commissioning organisations should ensure that the underlying principle of stewardship of the health of the population informs governance structures and decision-making processes and is integrated into each aspect of the commissioning cycle.

2. Governance structures influence decision-making and priority-setting. Commissioning organisations should assess governance structures for their impact on decision-making in relation to health and well being.
3. Governance processes within organisations predominate and commissioners, working in partnership, should also direct attention to governance across a local public health system.
4. PBC is largely focused on demand management with limited involvement in the JSNA, health and well being partnerships or assurance for WCC. PBC will require further development if it is to address all aspects of the commissioning cycle.
5. Local Enhanced Services are widely used by PCTs as financial incentives for GPs to provide preventive services but are optional and fragmented. A more strategic approach to the use of incentives by commissioners could build on evidence of pitfalls and potential areas of benefit and should also take account of the interplay of incentives across a health care system.
6. Further research is needed on the use of prioritisation tools and their applicability for prioritising investment in health and well being over the longer term and across all spend.
7. VCS involvement in commissioning strategies should be developed by local commissioners and ways of increasing public involvement in a preventive agenda explored. PCTs, PBC and local authorities should clarify the role LINks are to play in influencing commissioning decisions.
8. Further research is needed on the cost-effectiveness of public health interventions over the longer term in order to strengthen the business case for public health investment.
9. In each of the topic areas studied we found examples of innovative practice. We also found PCTs working independently on key topics, such as prioritisation methods, which would benefit from collaboration. We therefore suggest that methods for knowledge exchange in relation to the preventive agenda are given more priority by policy makers and researchers and that knowledge exchange spans the range of organisations involved in the health and well being agenda.

The report was completed just before a new coalition government signalled substantial changes to commissioning in the NHS, including the eventual abolition of PCTs. However the study raises generic issues related to commissioning for health and well being, exploring the complexity of governance for public health which goes beyond the governance arrangements of any single organisation.

1 Policy context and project aims

In October 2007 the National Institute for Health Research (NIHR) Service Delivery and Organisation (SDO) programme funded the research proposal 'Public health governance and primary care delivery: a triangulated study' as part of the research theme, 'incentives, performance and governance', under its public health research programme.

1.1 Policy context

Effective commissioning is a key priority for the NHS in England, reflected in the reinvention of Primary Care Trusts (PCTs) as commissioning organisations¹, the World Class Commissioning (WCC) assessment framework² and associated guidance³⁻⁵ and reinforced through an annual WCC assurance process. As part of the commissioning cycle, PCTs choose a minimum of ten health outcomes of which two, improving life expectancy and addressing health inequalities, are mandatory. This acts as a further lever for implementing policy commitments to improve health and address inequalities, reflected in a wide range of national policies, standards and targets. There has also been a policy emphasis on shifting the focus of the NHS towards prevention^{6, 7} and *The NHS 2010-2015: from good to great. Preventative, people centred, productive*⁸ emphasised the 'paradigm shift' required while at the same time improving productivity and integrated care centred on the patient.

However, shifting the balance of investment towards preventing ill health has proved difficult to achieve.⁹⁻¹² Various reasons have been put forward including: weaknesses in the public health evidence base and difficulties in assessing the cost-effectiveness of public health interventions; inadequate modelling of the costs of preventable morbidity and their impact on the NHS and the wider economy; failure to identify or track spend on prevention; and a lack of joined up strategies for addressing underlying determinants of health or the health consequences of policy. There is a widening gap in life expectancy between the most and least deprived populations¹³⁻¹⁵ and life expectancy for people in poverty has fallen further below the national average.¹⁶ Despite progress in meeting the objectives of *Tackling Health Inequalities: A Programme for Action*¹⁷ it has been argued¹⁶ that better use of 'tools and levers' is required, with higher priority accorded to addressing health inequalities. In a review of public health performance and spending, the Audit Commission¹⁵ highlighted variation in performance between Spearhead Local Strategic Partnerships (LSPs), demonstrating that 'local strategies can work' in areas of disadvantage, and therefore the potential influence of local commissioners.

Whether prevention is prioritised in practice is influenced by ways in which commissioning for health and well being is understood and then operationalised at a local level. Commissioning practice is framed by a complex system of incentives and governance arrangements which

influence priorities and decision-making. These include national guidance, policy priorities, Public Service Agreements (PSAs) and other national and local targets, the assessment activities of regulatory agencies, local governance and performance management arrangements, the nature of contractual flexibilities and the layering of incentives throughout the health care system.

1.2 Project aims and objectives

The aim of the project was to identify the impact of governance structures and incentive arrangements on commissioning for health improvement and on the health improvement activities of practices. Research objectives were as follows.

- Map incentives and governance arrangements in England for commissioning for health improvement and tackling health inequalities.
- Develop a conceptual framework for public health governance.
- Identify the impact of specific incentives, namely (a) Spearhead status (b) practice-based commissioning and (c) contractual flexibilities, on health improvement activities.
- Chart changes in selected measures of preventative health spending within PCTs.
- Assess the relative importance of specific incentives for health improvement for PCTs and practice-based commissioners.
- Identify (a) the current role of the public in decision-making related to public health and (b) perceptions of how effective involvement could be achieved.

An advisory group was established for the project and met twice. Ethics approval was granted by Newcastle and North Tyneside 1 REC on 20 March 2008 (REC reference number 08/H0906/11).

1.3 Policy developments

The project began in 2007, soon after the publication of the *Commissioning Framework for Health and Well Being*⁷ which outlined eight steps for effective commissioning, including putting people at the heart of commissioning, the development of the Joint Strategic Needs Assessment (JSNA) and of incentives for commissioning for health and well being, through Local Area Agreements (LAAs), contracts, pooling budgets, direct payments and practice-based commissioning. However, the period of the project, from October 2007 to March 2010, was one of rapid change: policy initiatives related to commissioning and changes in regulatory arrangements were implemented in quick succession between December 2007 and April 2009. Key developments were as follows.

- WCC² and the implementation of the WCC assurance system.⁴ The first round of WCC panel assessments took place in 2008, during the period of first phase interviews.
- Clear separation of commissioning and provider functions.^{1,18} This meant that PCTs were increasingly focused on their role as commissioning organisations.
- The introduction, in April 2008, of JSNAs, as outlined in *the Local Government and Public Involvement in Health Act* (2007).
- *High Quality Care for All*¹⁹ emphasised quality of care, clinical decision-making and personalised services and influenced the shape of commissioning strategies. The review also recommended that 'every primary care trust will commission comprehensive well being and prevention services in partnership with local authorities'. (p.9)
- Major changes in national regulatory arrangements through the launch of the Care Quality Commission (CQC) in April 2009, and, following implementation of the *Local Government and Public Involvement in Health Act* (2007), the introduction, also in April 2009, of the new Comprehensive Area Assessment (CAA).²⁰ This aligned processes of seven inspectorates in assessing partnerships and outcomes across a local area. It reports annually on the new national indicator set (NIS) and provides a scored judgment on direction of travel and on use of resources.
- For 2008/09 the annual operating framework (AOP)²¹ included a new performance framework, 'Vital Signs', with three tiers of performance measurement: national requirements, national priorities for local action and local priorities. Improving health and reducing health inequalities formed one of the five national priority areas. This was continued in the operating framework for 2010/11.²²
- Finally Patient and Public Involvement Forums (PPIFs) were abolished and replaced by Local Involvement Networks (LINKs) in every local authority area from April 2008. Established through the *Local Government and Public Involvement in Health Act*, they were intended to give citizens a stronger voice in how health and social services were delivered. LINKs are financially supported by local authorities until 2011, but for many of our case study sites interim arrangements were still in place.

These changes are relevant to governance arrangements and are interrelated. For example, competencies for WCC include partnership working (competency 2) and public involvement (competency 3); the CAA assesses local partnerships; JSNAs are intended to inform commissioning intentions of partnerships and the strategic direction for PCTs (competency 5) and Audit Commission assessments of PCTs on their use of resources incorporate information from WCC assessments. Inevitably these changes were reflected in the project and, in particular, in differences between the two phases of fieldwork. Moreover, the impact of the credit crunch on NHS finances post 2010/11 became clear with an associated emphasis on implementing the DH QIPP (quality, innovation, productivity and prevention) programme.²³ By the end of 2009, almost all PCTs in our case study sites had separated their provider arms from their commissioning functions, although the organisational form to be adopted by provider services was still to be decided. Because of the rapid pace of change, second phase interviews were less of a 'follow up phase' than an exploration

of new challenges for commissioning in general and for a focus on prevention in particular. This led to more focused discussions on prioritising investment and strategies for disinvestment, the challenges of performance management in primary care and how collaborative commissioning arrangements could be developed. While the first round of panel assessments of all 152 PCTs, carried out as part of the WCC assurance process was completed in 2008, the emphasis on achieving high levels of commissioning performance increased during the period of the study and was further prompted by the publication of a 'league table' of PCTs in March 2009.²⁴

Fieldwork therefore mirrors a period over which the WCC initiative shaped PCT commissioning activities and the CAA began to influence approaches to partnership. There were also organisational changes prompted by PCTs reconfiguring their roles and responsibilities better to reflect their role as commissioning organisations and to promote matrix working. This was the case in eight of our case study sites. If commissioning was the sole purpose of the organisation, then the post of 'Director of Commissioning', for example, appeared redundant.

Following the results of the election in May 2010 and the formation of a new coalition government, the White Paper *Equity and Excellence: liberating the NHS*²⁵ signalled major changes in the governance of the NHS in England. These included the abolition of Strategic Health Authorities (SHAs) in 2012, of PCTs from 2013, of PSAs, Overview and Scrutiny Committees (OSCs), the CAA after one year of operation, and arms length bodies, including the Health Protection Agency (HPA). Commissioning is to be carried out through new GP commissioning consortia reporting to a national NHS Commissioning Board. The timing of the project did not allow us to take account of these changes but the relevance of project findings in an emerging commissioning landscape is explored in the conclusions.

1.4 Structure of report

Following a description of methods (Chapter 2), the report reviews perspectives on governance (Chapter 3), and then summarises project findings on ways in which underlying values and the stewardship role influence the commissioning of health and well being at a local level (Chapter 4). Chapters five to seven discuss governance within organisations, governance between organisations and public accountability. Theories of incentives and their relevance for commissioners provide the context for Chapter 8 which analyses commissioners' use of incentives and contractual flexibilities for health and well being. The extent to which commissioners invest in health gain can be gauged by their prioritisation and decision-making processes and Chapter 9 analyses interview and survey data in the context of a review of prioritisation tools currently available.

Although governance and incentives are analysed separately, approaches to governance are linked with different kinds of incentives²⁶ and the final

section discusses what can be learned by comparing findings across these linked themes, drawing out implications for commissioners.

2 Methods

Mixed methods were used in this study. The exploratory phase comprised a mapping study, rapid reviews and focus groups. The fieldwork phase involved documentary analysis and semi-structured interviews in ten case study sites, with the analysis of interviews supported by NVivo. The national survey adopted a quantitative approach. Methods for each research activity are discussed in detail below.

2.1 Exploratory phase

The exploratory phase informed the development of research instruments and provided a framework for interpreting research findings.

2.1.1 Focus groups

Three focus groups were carried out in different venues across England during 2008. The aim was to explore views of national and regional stakeholders on dimensions of governance relevant to public health in order to inform a conceptual framework for public health governance and research instruments for fieldwork. A total of 50 potential participants with a national profile or holding senior regional public health, commissioning or finance posts across England were contacted, and 16 were able to participate. Of these, four cancelled and were interviewed individually by telephone. Focus Group one (national) had four participants (plus five project team members), Focus Group two (regional) had six participants (plus six project team members) and Focus Group three (regional) had two participants (plus four project team members). Project team members acted as observers. Focus groups lasted for two hours and were facilitated by a member of the project team, guided by a focus group protocol (Appendix 1). Focus groups and interviews were transcribed and main themes were identified inductively by two members of the project team on a separate basis and then compared. A detailed analysis (working paper 1 (SC, LM, DJH (<http://www.dur.ac.uk/public.health/projects/project3/>)), was then discussed by the project team, most of whom had attended one or more focus groups. The findings formed the basis of an article.²⁷

2.1.2 Scoping studies

A descriptive mapping exercise (SC) on incentives and governance arrangements and their implications for the health and well being agenda drew on the experience of the project team and documentary analysis of standards, targets and performance management regimes in PCTs and local authorities. A scoping study of public health governance (working paper 2 (LM, SC, DH, JM)) was based on rapid literature reviews of governance and public health governance and also drew on the experience of the project

team. It incorporated the descriptive study of targets, performance management regimes and regulatory arrangements and focus group findings. An economics review brought together economic perspectives on incentives, their potential relevance for commissioners, issues arising in the economic evaluation of public health interventions and an assessment of the relevance of prioritisation tools currently available (working paper 3 (JM, AM, HW)). Prioritisation tools were identified through existing knowledge of the project team, a review of key literature, web-based searches and through informal consultation with experts in the field. The potential impacts of incentives on public health were examined by applying several theoretical approaches found within the economic literature. This drew on and extended a previous review of governance, incentives and outcomes by Davies and colleagues.²⁶

2.2 Developing research instruments

Interview schedules were informed by the exploratory phase. Draft interview schedules were piloted with two interviewees (reflecting public health expertise and the voluntary sector) and were subsequently modified during fieldwork to reflect (a) the role of the interviewee and (b) changes that had taken place between the first and second phases of field work. Interviews covered commissioning arrangements; the impact of performance management systems, regulatory arrangements and standards on commissioning for health and well being; incentives for commissioning for health and well being; decision-making and investment for health; and stewardship. Examples of interview schedules from each phase are included in Appendix two. Consent was obtained to record interviews which were then transcribed using a professional agency.

2.3 Fieldwork

Field work was carried out in ten case study sites across England: selection of sites and recruitment of participants are described below.

2.3.1 Selection of case study sites

Sites were selected to reflect:

- An equal number of Spearhead and non-Spearhead PCTs, to include one of each within London
- Urban and rural areas
- A spread of SHAs
- A range of population size
- Different ratings in relation to quality of services and use of resources as assessed through the Healthcare Commission Annual Health Check (2006/7)
- A number of PCTs which rated highly on new national targets, as outlined in *National Standards Local Action, Health and Social Care Standards and Planning Framework 2005/6-2007-8*,²⁸ including health inequalities and rates of smoking (as measured in the Healthcare Commission ratings of 2006/7)

- Sites which were not over researched or included in other projects funded under the NIHR SDO public health research programme.

Although selection of sites took place before the WCC assurance process and the publication of a league table in 2009,²⁴ a reasonable spread of WCC achievement was reflected with four PCTs in the top quartile, three in the second quartile, one in the third quartile and two in the fourth quartile.

Selected PCTs were initially contacted by letter to request agreement in principle. We also identified alternative potential sites which met our criteria. A total of 12 PCTs declined to participate in the study due to time pressures or the co-existence of other research projects. However we achieved recruitment of sites according to our criteria. Field work consisted of two phases of interviews and documentary analysis, which are discussed in turn.

Table 1. Selection of case study sites

Site	Spear-head	Use of resources	Urban	Pop. over 300,000	Quality of services	New national targets
1	No	Weak	Yes	No	Fair	Weak
2	Yes	Weak	No	Yes	Fair	Weak
3	No	Weak	Yes	No	Fair	Fair
4	Yes	Fair	Yes	No	Good	Good
5	Yes	Good	Yes	No	Good	Good
6	Yes	Fair	Yes	Yes	Good	Excellent
7	No	Weak	Yes	Yes	Weak	Weak
8	Yes	Fair	Yes	Yes	Excellent	Excellent
9	No	Fair	Yes	Yes	Fair	Weak
10	No	Weak	No	Yes	Weak	Good

2.3.2 Recruitment

Phase one involved interviews with 78 participants across the ten sites spanning PCT Chief Executives and Chairs, Directors of Commissioning, Finance and Public Health, Practice-based Commissioning (PBC) leads, Professional Executive Committee (PEC) Chairs, Non-Executive Directors (NEDs), Chairs of the local Overview and Scrutiny Committees (OSCs) for Health, voluntary and community sector (VCS) representatives on Health and Well being partnerships of the LSP and Chairs of the recently formed LINKs.

Interviews (mainly face to face with some telephone interviews) were carried out between October 2008 and April 2009. Table 2 shows that we achieved a balance of PCT decision-makers, PBC leads and community members across each of the sites. Where there were joint positions we interviewed both incumbents and in one site, due to the boundaries of the PCT spanning two borough councils, additional participants were recruited.

Table 2. Recruitment for phase one interviews

	Case study site										
Interviewees	1	2	3	4	5	6	7	8	9	10	Total
Chief Executive	R	R	R	D	D	D	D	D	D	D	3
Director of Commissioning/ Strategy	R	R	RT	R	R	R	R	R	RT	RT	10
Director of Public Health	R	RT	-	RT	Rx2	R	R	R	RT	R	10
Director of Finance	D	R	RT	R	R	R	R	D	R	D	7
Non-Executive Director	R	D	R	R	R	D	R	D	R	RT	7
PEC Chair	R	R	R	N/A	R	D	D	R	R	R	7
PBC Lead	D	RT	RT	D	Rx2	R	R	RT	RT	D	8
Health Scrutiny Committee Chair	R	D	R	Rx2	D	R	D	D	D	R	6
LINK Chair	N/A	N/A	R	N/A	R	R	R	R	R	D	6
VCS member of Health Partnership	R	R	RT	RT R	R	R	D	R	R	RT	10
Additional interviewees	1			1	2						4
Total	8	7	9	9	12	7	6	6	8	6	78

R: Recruited (face to face interview) RT: Recruited (telephone interview)

D: Declined; N/A: Not applicable or post not filled

The follow up phase was intended to update developments and was more limited in scope, with two or three interviews carried out in each of the ten case study sites. Timing maximised the gap between the first phase (2008-2009) and the second phase (2009 - early 2010) (range 8 -11 months). First phase interview schedules were amended and updated (see Appendix 2 for examples) and 21 interviews were carried out between September 2009 and January 2010. We aimed to interview the DPH in each of the case study sites as well as one other. Choice of the latter was influenced by any major gaps in the first phase: recruitment is summarised in Table 3. There were four new interviewees and 17 follow up interviews.

Table 3. Recruitment for phase two interviews

	Case study site										Total
Interviewees	1	2	3	4	5	6	7	8	9	10	
Chief Executive	-		-	-	-	-	-	-	-	-	
Director of Commissioning/ Strategy	D	-	-	R	-	-	RT	D	D	RT	3
Director of Public Health	R	RT	RT	-	Rx2	RT	RT	RT	D	D	8
Director of Finance	-	-	-	-	-	-	-	-	RT	-	1
Non-Executive Director	-	-	-	-	-	-	-	-	-	-	-

PEC Chair	-	-	-	-	-	-	RT	-	-	-	1
PBC Lead	R	RT	-	-	R	-	-	-	-	RT	4
Health Scrutiny Committee Chair	-	-	-	-	-	-	-	-	-	-	-
LINK Chair	-	-	RT	R	-	RT	-	-	-	-	3
VCS member of Health Partnership	-	-	-	-	-	-	-	-	-	-	-
Additional interviewees									1		1
Total	2	2	2	3	2	2	2	2	2	2	21

2.4 Interview analysis

All interviews were recorded and transcribed with interviewees' permission. A thematic analysis of first phase interviews was carried out by two members of the project team. This was complemented by a systematic analysis of all interviews supported by NVivo and a detailed analysis completed (working paper 4 (SC)). This involved developing five frameworks (PCT interviewees, PBC leads, OSC members, VCS Health Partnership members and LINK members) which allowed common themes in each group to be identified. The analysis was then extended to allow themes to be compared across groups of interviewees and across case study sites. Analysis was discussed by two members of the team and any differences of interpretation were resolved. Second phase interviews were fewer in number and were not integrated into the NVivo analysis. A thematic analysis was carried out and discussed by two members of the project team (working paper 5 (LM)).

2.5 Documentary analysis

A documentary analysis was carried out (SC) for each of the case study sites in order to compare key documents for 2008/9 and 2009/10, including: the five year Commissioning and Strategic Plan (CSP), the Annual Operating Plan (AOP), the Director of Public Health (DPH) Report and the JSNA. Analysis was informed by the exploratory stage and the interview analysis and covered the following topics: the alignment of commissioning intentions to local health needs; the involvement of PBC in commissioning for health and well being; partnership involvement; investment for health and well being; and incentives for health and well being services.

The first phase of document collection was carried out as part of phase one fieldwork. Where documents for 2008/9 could not be easily accessed through website or site contacts, Freedom of Information (FOI) requests were made. Not all documents for 2009/10 could be accessed in time to be included in the analysis.

2.6 National survey

Drawing on key findings generated through first phase fieldwork, a national survey of PCTs was carried out in two waves between October and December 2009 (working paper 6 (AW, SP)). As a research team we

discussed various definitions and defined health and well being at the beginning of the survey as: 'health improvement through public health measures focusing on health promotion, preventative care and community involvement'. The survey explored how PCTs prioritise, incentivise and commission health and well being services. After several iterations with input from all members of the project team, the survey was piloted on five contacts from PCTs, including a DPH, Director of Primary Care Commissioning and NEDs. The survey was piloted in September 2009 with results and comments fed back into a final iteration of the survey.

The survey was distributed through the web tool Survey Monkey, an accessible, easy to use on-line survey. We stopped collecting responses on December 31st when a plateau in collection rates was reached. The survey was sent to 508 individuals across 146 out of a total of 152 PCTs (an average of 3.5 individuals per PCT), reflecting the fact that a number shared Boards and were treated as one PCT. Individuals fell into four categories: PCT Board Chair, Director of Public Health, PEC Chair or Medical Director and Director of Commissioning. Responses were received from 65 per cent (95/146) of PCTs (Table 4). The survey enabled us to locate case study findings in a national context.

Table 4. Survey sample

	Invitations sent	Responses	Percentage completed
Board Chair	135 (full coverage = 146)	34	25
DPH	133 (full coverage = 139)	52	38
PEC Chair	118 (full coverage = 139)	28	24
Director of Commissioning or equivalent	122 (full coverage = 130)	24	18
Total	508 (full coverage = 555)	138	27

In 38 per cent (55) of PCTs there was one respondent; in 23 per cent (34) of PCTs there were two respondents; and in four per cent (6) of PCTs there were three or four respondents. Where this has implications for the analysis this has been accounted for and the results have been adjusted.

2.7 Data synthesis and limitations of the study

The study drew together findings from different research activities: scoping studies; qualitative data gained through interviews; quantitative data gained through the national survey and documentary analysis. An iterative approach was taken so that the focus groups and scoping studies carried

out in the exploratory phase informed the conceptual framework and the development of first phase interview schedules; first phase interviews influenced the development of the national survey as well as the documentary analysis. Analysis of first phase interviews influenced second phase interview schedules. For example, the importance of LESs and of prioritisation processes in commissioning for health and well being became more evident as the study progressed.

As outlined in Chapter 1, the study had to take account of numerous policy changes. For example, WCC was not included in the study proposal as it had not yet been developed. This was a key influence on PCT strategy and attempts to align health needs, commissioning intentions and financial planning.

There are limitations attached to each research activity. Focus group participants were few in number and there were last minute cancellations. Four of those who cancelled were interviewed separately. Documents were not readily available and often sourced through FOI requests and the analysis was limited to two years rather than the three years originally anticipated in the proposal. The selection of case study sites and recruitment of interviewees was largely as anticipated although there were delays in setting up LINKs nationally which were reflected in our sites. Most interviews were carried out face to face in the first phase.

The response rate for the national survey was 65 per cent of PCTs and this limits the generalisability of findings. Moreover, the national survey was limited to PCTs and therefore limited within-study comparisons. We analysed themes within and between case study sites and also compared findings with the national survey. Inconsistencies are highlighted in the report. The report integrated theoretical perspectives with both qualitative and quantitative data in relation to key themes.

2.8 Developing a conceptual framework

The exploratory studies enabled us to develop a conceptual framework which informed the development of research instruments and the analysis of case study data and is reflected in the structure of the report. This framework draws together separate influences on the governance of public health including the impact of current performance management regimes on the health and well being agenda (Chapter 5); the complex governance landscape to be negotiated for governance of public health including governance between organisations (Chapter 6); public involvement in commissioning (Chapter 7); prioritisation processes (Chapter 9) and the influence on commissioning of underlying values of stewardship of the health of the population (Chapter 4). The latter influences the implementation of performance management regimes, the emphasis placed on partnerships and public accountability, the nature of commissioning intentions and the extent to which they are prioritised in practice. It can also influence the use of incentives for preventive services. Chapter 8

discusses this aspect in the context of theoretical approaches to incentives and the impact of incentives layered into the health care system.

Through detailed analysis of interviews and selected documents in the ten case study sites we were able to construct portraits of each of the ten case study sites (Appendix 3) and compare key themes including the impact on commissioning for health and well being of performance management arrangements, the use of incentives and decision-making processes. Analysis of key themes in Chapters 4–9 draws on case study and national survey data.

The report draws together findings from the different phases of research, allowing us to locate fieldwork in a national context and interpret our data in a theoretical framework.

3 Perspectives on governance

The notion of governance has acquired growing importance as governments in the UK and elsewhere reform public services and redefine their responsibilities and relationships. However, 'governance' is a notoriously slippery term. It may be associated with a set of principles, the exercise of legitimate authority through law and regulation, standards and targets, or processes for ensuring accountability and managing risk within organisations. It may also apply to the systematic application of procedures. Studies of governance may focus on specific topics (as in clinical governance), identify new challenges which arise through multi-level, multi-agency or participatory governance arrangements, or clarify how principles of governance are reflected in different decision-making contexts. *The Healthy NHS Board*²⁹ identifies five models: the agency model, which includes performance management regimes, incentives and sanctions; the stakeholder model, which involves engaging and balancing a multiplicity of stakeholder views; the stewardship model which engages with civic society through developing a framework of shared values; policy governance which distinguishes between the public and those who deliver services on its behalf within a policy framework; and 'generative governance' which involves active dialogue across board, staff and users. A single definition is elusive and authors argue that 'a sound understanding of governance derives from assimilating and blending this range of perspectives' (p.40). However, as evidenced by the investigation into patient safety failures at Mid-Staffordshire NHS Foundation Trust,³⁰ some aspects of governance, such as meeting specific targets, may dominate at the expense of others, such as openness and promoting the values of the organisation.

On the basis that the impact of governance structures on commissioning for health and well being should be considered in the light of different approaches to governance, this chapter begins by identifying perspectives on governance: subsequent chapters consider their relevance for commissioning for health and well being. Working paper two provides a more detailed account.

3.1 Principles and processes

Underlying principles of governance shape decision-making. At a cross-national level the Worldwide Governance Indicators Project³¹ includes six broad dimensions of governance which allow governance arrangements to be measured across countries, namely: accountability; political stability; government effectiveness; regulatory quality; rule of law; and control of corruption. These broad principles are reflected in other approaches to governance. At an organisational level, the Independent Commission on Good Governance in Public Services³² notes that 'good governance leads to good management, good performance, good stewardship of public money, good public engagement and, ultimately, good outcomes' (p.v) and,

building on the Nolan principles for the conduct of individuals in public life, it outlines six core principles of good governance.

- Focusing on the organisation's purpose and on outcomes for citizens and service users.
- Performing effectively in clearly defined functions and roles.
- Promoting values for the whole organisation and demonstrating the values of good governance through behaviour.
- Taking informed, transparent decisions and managing risk.
- Developing the capacity and capability of the governing body to be effective.
- Engaging stakeholders and making accountability real.

Stewardship of the health of the population has also been identified as a core principle of governance and is further discussed in section 3.5, below.

At a corporate level, governance encompasses the processes, policies and laws affecting the ways in which corporations are controlled, and managers and others are held to account. The Audit Commission³³ defined corporate governance as

'the framework of accountability to users, stakeholders and the wider community, within which organisations take decisions, and lead and control their functions, to achieve their objectives.' (p.4)

Corporate governance supports effective decision-making at Board level, within a clear framework of accountability and in the context of a national system which sets standards and monitors through independent systems of regulation. The nature of performance management changes over time and target-driven cultures have been criticised for their 'short-termism' and 'neglect of wider organisational objectives'.³⁴ (p.6)

It is also recognised that performance management systems have often proved ill-suited to complex and multi-factorial problems such as tackling health inequalities,³⁵ or obesity,³⁶ which require cross-cutting, multi-agency action. There may also be tensions between national targets and local needs assessments or local engagement.³⁷ The impact of standards and targets on commissioning for health and well being is further discussed in Chapter 5.

Underlying principles of governance and the ways in which these are reflected in corporate governance arrangements form only part of the picture. Public organisations work in complex governance landscapes and reflect different modes and approaches to governance. These are described in turn.

3.2 Modes of governance

While principles of governance and processes of corporate governance are broad and uncontentious, there is far greater debate over modes of governance and their impact. Modes of governance have typically been classified into markets, hierarchies or networks, and research has identified how they are reflected in public services as a whole or within specific organisations. This tripartite categorisation is considered too simplistic given the hybrid, or mixed forms of governance which currently co-exist within

publicly-funded services. One form of governance (such as contracts) may obtain within another (such as hierarchical structures). In practice, there are varying blends of local flexibility, central control and regulation, reflecting the notion of 'soft bureaucracies'.^{37, 38} Modes of governance may co-exist in practice and the balance between them changes over time. In an attempt to codify approaches to governance, Treib et al.³⁹ argue that while the form of government or of social organisation may reflect an 'ideal type' of hierarchy at one end and markets at the other, in practice each form of governance may incorporate others. They also argue that different modes of governance, including degree of regulation, rigid or flexible approaches to implementation or degree of enforceability apply to 'steering instruments' (such as incentives, regulations, social influence and control). This point is returned to in Chapter 5 in relation to the implementation of national targets.

The NHS has elements of each form of governance, and has been described as a combination, from its inception, of 'quasi-hierarchy, quasi-markets and quasi-networks'⁴⁰ although, unlike its counterparts in Scotland and Wales, the English NHS has increasingly embraced elements of the market, while continuing to work through organisational forms based on trust. Greener and Powell⁴¹ document a series of tensions that have emerged in the NHS through governance changes, arguing that current market reforms provide structural competition but 'lack any underpinning idea of how the market is meant to operate'. Networks, although widespread in the NHS, cannot depart from national directives. The NHS is still a largely centralised system with policies filtered through national targets and priorities reflected in performance management systems and detailed assessment of standards through the activities of independent regulatory agencies: the CQC (from April 2009); Monitor; the Audit Commission; and the National Audit Office. PCTs are also involved in a combination of horizontal partnerships (such as LSPs) and hierarchical relationships with SHAs and the Department of Health (DH). *'The Healthy NHS Board'*²⁹ notes that DH at central and regional levels, major regulators and NHS Boards all share accountability, power and authority. Different approaches to governance thus co-exist and cross-cut and the balance across them changes over time.

Tensions arise not solely as a result of the co-existence of markets, hierarchies or networks, but also as a result of 'newer' forms of governance layered on to existing arrangements, discussed in more detail below.

3.3 Complex governance landscapes

The three modes of governance do not capture the complexity of the current governance landscape which includes: governance across different levels; partnerships across different organisations; and participatory governance which emerges from attempts to increase accountability, a key principle of governance, through community engagement. These 'newer' forms of governance are briefly described in turn.

3.3.1 Multi-level governance

There are different 'tiers' or 'levels' of governance, ranging from EU directives and incentives to partnerships at sub-regional and community levels, which interrelate in different ways, adding a further complexity to collaboration within any single forum or across different geographical areas.⁴² In a study of multi-level governance, Townsend⁴³ documents the different levels of governance that have been instituted in England 'at different dates and for different purposes' commenting on the complex and sometime ambiguous accountability arrangements which emerge and the capacity for 'jumping' across different layers of governance. He argues that working across institutional boundaries through personal networks has been shown to be an important indicator of success in negotiating the complexities of multi-level governance, a point returned to in sub-section 4.1.4 in discussion of the role of leadership in negotiating different governance arrangements.

3.3.2 Governance between organisations

Improving population health involves working across different sectors in complex partnership arrangements with multiple accountabilities, where success is dependent on building sustainable coalitions. *Strong and Prosperous Communities – the Local Government White Paper* calls for 'more visible local leadership for health and well being',⁴⁴ (p.14) joined up performance management and 'greater clarity' over agreeing and delivering local health and well being targets. In recognition of this, partnership governance frameworks and toolkits have been developed.⁴⁵ Partnerships involve risks as well as benefits and, as Bullivant et al.⁴⁶ point out, definitions of contracts, networks and partnerships differ between organisations and professional groups. Organisations need assurance from partners that they have identified 'risks to overall objectives and put adequate controls in place'. (p.2) A report on NHS Board governance²⁹ highlighted the importance of partnership agreements, clear perspectives on care pathways, transparency of strategic decision-making and clarity of outcomes, all of which should be reflected in arrangements for reporting and monitoring performance, managing risk and ensuring accountability. Partnerships create new governance challenges and Tuohy,⁴⁷ for example, writes of the need for a 'new governance paradigm' to 'connote the processes and instruments of governing in the context of complex organisational networks in which no one set of actors has the authority to 'command and control'. Chapter 6 considers this aspect in more detail.

As described further in Chapter 4, focus group participants and interviewees considered partnership arrangements as a key area of governance concern for public health, given the significance of partnership working in addressing wider determinants of health, health inequalities and investment across the public sector. It was also an area where governance arrangements required further development.

3.3.3 Participatory governance

Accountability is an underlying principle of governance and community participation has generated a new vocabulary of governance, including terms such as, 'community governance', 'citizen-centred governance' and 'participatory (local) governance'. Barnes et al.⁴⁸ define citizen-centred governance as follows:

'How to create flexible and effective organisations for delivering public services that also reflect the values of local democracy. We call this 'citizen-centred governance.' (p.1)

The commitment of the main political parties to devolving power to local democratic structures, users and local communities reflects values of choice and diversity in public services and increased accountability. Formal structures for user involvement are now embedded within health, education and local authority systems, reflecting the importance attached to civil renewal, civic participation in governance and the improved delivery, management and scrutiny of public services. Community engagement is also seen as key to the regeneration of disadvantaged communities. For example, a capacity to engage effectively with the VCS was identified as a key factor for LSPs if they were to address social exclusion, help regenerate neighbourhoods and reduce the 'health divide' for their local area, although, as further described in this report, this has proved difficult to achieve.

In England, the importance of public involvement and local engagement for health and well being was restated in *A Stronger Local Voice*,⁴⁹ *Strong and Prosperous Communities - the Local Government White Paper*,⁴⁴ and in the *Local Government and Public Involvement in Health Act* of 2007. The White Paper *Communities in Control: Real People, Real Power*⁵⁰ described ways in which people could exert more influence in decision-making, while *Real Involvement: working with people to improve services*⁵¹ outlined principles for local accountability and guidance for the NHS on the duty to involve. A spectrum of involvement was outlined including involvement in commissioning decisions across the commissioning cycle, in practice-based commissioning and representation in governance structures (p.28). LINKs are also identified as a source of information for commissioning. The importance attached to patient and public engagement is also reflected in competency three for WCC.

This policy agenda is reflected in a complex blend of structures and accountability arrangements at a local level. In England, structures for community governance include: ward-based neighbourhood or local area forums; regeneration partnerships; LSPs, which are intended to encourage VCS involvement in prioritising local services; LINKs, which span health and social care across a local authority area; and Foundation Trusts (intended to promote a level of community ownership, through elected community governors). While the localism agenda is intended to help shift the balance from 'government' to 'governance', Barnes et al.⁴⁸ describe a 'patchwork of governance arrangements' arising from a plethora of statutory agencies, partnerships and boards. Such developments co-exist with local authority democratic structures based on representative democracy, appointed PCT Non Executive Directors, and various arrangements for consultation with the

public over service developments. At a local level, the mix of governance arrangements can lead to consultation overlap, confused accountability and lack of clarity over representation. Moreover, newer forms of governance may not have formal legal status, and show lower levels of transparency and accountability to the public than statutory bodies. There are also disagreements over the extent to which a shift in meaningful engagement is being achieved in practice.⁵²

Despite the emphasis on public involvement the drive for greater efficiency has created services which cover larger geographical areas which are remote from local decision-making. These issues are of relevance for commissioners as commissioning organisations combine to achieve economies of scale but have a duty to engage with local populations.

Also intended to strengthen patient and public accountability and working closely with LINKs are OSCs for health, set up in 2003 to scrutinise health services and health issues and identify areas of concern to the public. The guidance⁵³ notes that:

‘The Government’s intention is that the focus of health scrutiny is on health improvement, bringing together the responsibilities of local authorities to promote social, environmental and economic well being and the power to scrutinise local services provided and commissioned by the NHS’. (p.6)

Chapter 7 discusses in more detail public involvement in commissioning health and well being services.

3.4 Topic-based approaches

Governance arrangements are sometimes applied to specific topics such as clinical governance, digital governance or carbon governance. Despite arguments that clinical governance be incorporated within a system of integrated governance, a report by the Audit Commission³³ highlighted the existence of separate governance streams for clinical governance and corporate governance in committee structures beneath PCT Board level. It concludes that:

‘The consequences of this are that the clinical arm of the organisation wants to, and often does, deliver excellent clinical care to some individual patients, but not always with due regard for equity, finance and the bigger community picture’. (p.12)

While their report highlights the importance of combining these streams of governance, it also serves to draw attention to the historical emphasis on clinical governance and the neglect of a parallel concept of ‘public health governance’. Arguably, this emphasis on clinical governance and its status as a reference point for quality assurance works against the development of its public health equivalent, and governance issues central to public health have not been fully developed through clinical governance arrangements. In a qualitative study which identified the views of managers on the pattern of incentives and regulatory structures in place in relation to promoting health Hunter and Marks⁵⁴ argued that the fact that public health was largely considered as part of the NHS rather than as part of a wider health public health system lay behind the ways in which incentives and performance

management regimes had been skewed towards health care. Taking their cue from the concept of clinical governance, the authors argued that:

‘A similar definition might be produced for public health governance to include excellence in promoting population health’. (p.43)

The relationship between stewardship and public health governance is further discussed below.

3.5 The concept of stewardship and public health governance

The World Health Organisation (WHO) refers to collective responsibility for protecting the health of the population as the stewardship role of government:⁵⁵

‘The careful and responsible management of the well-being of the population – stewardship – is the very essence of good government. The health of people is always a national priority: government responsibility for it is continuous and permanent.’ (p.viii)

The notion of ‘public health governance’ has been described along similar lines to stewardship as the ‘means by which society collectively seeks to assure the conditions under which the population can live with the highest possible level of health and well being’.⁵⁶

Developing this notion, the Nuffield Council on Bioethics⁵⁷ expanded on the ‘stewardship model’ of the state in relation to public health, commenting that:

‘The stewardship state, in addition to protecting its citizens from harm caused by others sees itself as having a responsibility for protecting the health of vulnerable groups, such as children and in closing the gap between the most and least healthy.’ (p.v)

One of the critical identifiers of whether a country exhibits good governance is the state of the health of its population including its commitments to equity and social justice; a focus on social and economic aspects influencing health and well being; and changing risk factors across whole populations. In its opening statement, the WHO Commission on Social Determinants of Health⁵⁸ reiterates the impact of social and economic policies on life chances and squarely locates these issues within an agenda for social justice:

‘The development of a society, rich or poor, can be judged by the quality of its population’s health, how fairly health is distributed across the social spectrum, and the degree of protection provided from disadvantage as a result of ill-health’.

In the commission’s report, health and health equity are considered to lie at the heart of governance. Health equity is considered a marker of government performance and it is argued that the impact of policies on health equity should be assessed and the stewardship role of government strengthened. Policy coherence across different departments of government is considered key, as is identifying the health impact of policies and acting on the results. The subsequent application of the commission’s approach to England, *Fair Society Healthy Lives*¹⁴ outlined the priority objectives and policy recommendations across six key policy areas if entrenched health inequalities were to be addressed.

If this approach to stewardship is pursued then, at a national level, the ways in which the stewardship role of government is discharged influence the extent to which a concern with the health of populations permeates policy development, health impact assessment, priority-setting, and decision-making. It may be reflected in the balance between 'upstream' and 'downstream' interventions; in the extent to which prevention of ill health is resourced and prioritised; the extent of health inequalities or levels of citizen engagement and social inclusion. While the scope and function of the public health profession, the public health function and a public health system have been variously defined over time (see review in Hunter, Marks and Smith),⁵⁹ analysis of the governance arrangements implied by goals of maximising population health, or the development of a local public health system remain relatively neglected.

The stewardship role raises ethical issues and the Nuffield report⁵⁷ suggested an ethical framework for scrutinising public health policies, also identifying ethical issues involved in making choices over priorities, including problems with the QALY as a way of evaluating public health programmes (see detailed discussion in Chapter 9). It reflects growing interest in the field of public health ethics.⁶⁰⁻⁶³ This refers to the range of moral and ethical issues which arise from societal approaches to protecting and promoting health at a group or population level, reflecting the fact that topics central to public health are not adequately covered in mainstream medical ethics.⁶⁴ There are debates over the balance to be negotiated across personal and collective responsibility,⁶⁵ across public and private interests, or the rights of the community over personal freedoms. Gostin and Stone⁶⁶ argue for a new public health ethic committed to 'ideas of community and partnership'.

Stewardship also raises ethical questions over the primacy of health and health improvement in decisions taken in other sectors which may have a bearing on health. However, as Peckham and Hann⁶³ point out, the Nuffield report did not provide a framework for the application of ethical concepts in public health practice. By extension, neither does it consider how the stewardship role is reflected in the decision-making processes of local commissioning organisations.

While links can be forged between responsibilities for collective well being, good governance, public health governance and a stewardship role, there are differences in how these concepts are understood and operationalised. Public health ethics reflects related concerns over the notion of the common good, 'health citizenship' and the nature of civic engagement and responsibility. Wikler and Brock summarise ethical issues in public health as follows.⁶⁷

- Decisions over the extent of personal responsibility for health.
- Priority-setting within existing resources.
- The use of cost-effectiveness analysis (for example, how to compare gains in life expectancy of the population with individual benefits from treatment).
- The balance to be negotiated between maximising and equalising population health.

- Reducing risks across whole populations, as opposed to targeting high-risk groups.
- Criteria for distributing resources across different groups.

There are few studies exploring how practitioners negotiate ethical dilemmas in public health practice, or how 'occupational risks' of public health practice, categorised by Cribb⁶⁸ as paternalism, healthism and 'unqualified utilitarianism', are to be negotiated.

This rapid review of governance provides a context for understanding different approaches and tensions being played out in commissioning practice which are reflected in the field work carried out as part of the project. Subsequent chapters explore the following as of particular relevance to public health: approaches to stewardship and public health governance; governance within organisations; governance between organisations, public involvement in commissioning for health and well being, the use of incentives and the extent to which health promotion is prioritised in decision-making processes.

4 The stewardship role and commissioning for health and well being

There is debate over whether a value-based approach to governance, or 'good governance', distorts essential generic properties of governance, that is, arrangements that entities make for their functioning. However, commissioners' commitment to public health values can influence approaches to governance arrangements as well as the deployment of incentives. This is indicated by the relative emphasis accorded to specific targets, partnership governance, the use of incentives for preventive services or the extent to which investment in health and well being is prioritised. Moreover, governance of public health raises specific issues which may not be adequately reflected in current governance arrangements.

This chapter begins by looking at the stewardship role at a local level and then draws on views from focus groups, interviewees and national survey respondents to discuss stewardship and the values which support a health and well being agenda (4.1). It then discusses views of practice-based commissioners on this topic (4.2) before discussing the impact of WCC on developing a public health-led model of commissioning (4.3).

4.1 *Stewardship at a local level*

There are parallels between a stewardship role at a national level, as described in the previous chapter, and a stewardship role at a local level. This is reflected in the requirement for both primary care organisations and local authorities, singly and working in partnership, to protect and promote the health of their populations. The first of the three main functions of PCTs is to engage with the local population to improve health and well being.⁶⁹ This has three elements.

- Improving the health status of its population, and reducing health inequalities, in partnership with local authorities.
- Contributing to well being and sustainable community development, in partnership with local authorities.
- Protecting health including through a robust system of emergency planning.

These aims are reflected in a range of organisational governance and performance management arrangements within and between organisations. *The Healthy NHS Board*²⁹ reiterates the importance of Boards 'looking out to their patients, to their communities and to their partners', noting 'the enduring principles of high quality governance which transcend immediate policy imperatives and the more pressing features of the current health care environment.' (p.6) The importance of adopting a whole health economy perspective for health improvement and prevention is emphasised, as is the adoption of 'system governance' (p.32).

Local authorities have a duty to promote social, economic and environmental well being through their Community Strategies as set out in the *Local Government Act* (2000) and now replaced by Sustainable Community Strategies. *The Local Government and Public Involvement in Health Act* (2007) places a statutory duty on PCTs and local authorities to work together on JSNAs, in order to identify the health needs of their local population.

4.1.1 Changing notions of stewardship

Interviewees and focus group participants commented on changing notions of stewardship, the complexity of governance for public health, the nature of governance failure and enablers for the health and well being agenda.

While stewardship of the health of the population was considered a key principle of governance, focus group participants described how notions of stewardship were changing from a top-down, collective approach to one based on choice. This change could be tracked through the increasing influence of the personalisation agenda in health and social care, a movement towards deprofessionalisation and local engagement, increased interest in incentivising individual behaviour change, increasing the capacity to exercise choice and using social marketing techniques. However, tensions remained over the balance between individualised and collective approaches, and these were key to understanding governance of public health:

‘The core of what public health faces, which is how much we emphasise the collective over the individual, how much the collective becomes the aggregate of individual decisions, rather than collective decisions imposing individual behaviour.’ (National focus group)

Interviewees from all groups also raised questions over the balance between individual responsibility and the responsibility of the PCT, which forms part of the complexity of the governance of public health, further discussed below.

4.1.2 Complexity of governance for public health

The complexity of governance arrangements relevant to improving health was a common thread in the focus groups: concentrating on certain aspects of governance could lead to the neglect of others. For example, focusing on organisational governance arrangements within the NHS could deflect attention from underlying principles of stewardship across a local public health system. Effective stewardship involved understanding what could be achieved at national, regional, or local levels and recognising the breadth of a local public health system, along with the levers for change across the public sector. Participants argued that public health governance should therefore reflect a broader public health system, including social and economic regeneration and social care, rather than be associated with a professional group or with the NHS. One participant noted that:

‘It is for me also increasingly difficult to talk about public health in isolation from sort of public health and well being and the broader links into local regeneration by social and economic

regeneration strategies. And I find it quite artificial to separate it out into a sort of compartment of its own, both at that end but also in terms of its links into social care, care of the disadvantaged too. It's the broader basis.' (National focus group)

This approach would involve identifying how resources could be mobilised across the public sector as a whole and it was argued that current governance systems did not enable this debate. Public health professionals should clarify the health consequences of public policy, planning and economic decision-making. This implied holding agencies to account for preventable mortality across the system.

While clarity over accountability formed a key dimension of governance, focus group participants argued that accountability for health and well being remained dispersed and pathways ill-defined. If complex arrangements were to be successfully negotiated and health integrated into the range of governance structures, effective leadership was required.

For PCT interviewees the stewardship role was often associated with the effective and systematic implementation of the commissioning cycle.

Stewardship of the health of the population was described as the *raison d'être* of the organisation, 'the entire business of the PCT', embedded throughout the commissioning cycle, and reflected in investment priorities and in decision-making processes. Governance was about ensuring that processes were in place to link together health needs, strategy, investment and outcomes:

'The stewardship lies with NHS ... which is what we are, and we have to make sure that our information, our planning, our strategy is absolutely geared into delivering that, and that the contracts and the things that we buy The stewardship is a really essential role, and I feel very responsible in terms of carrying the weight of that going forward.' (PCT Board Chair, Phase 1)

Effective governance was associated with processes of governance related to national standards, public accountability, a clear idea of the organisation's purpose and oversight of what needed to be in place to achieve the best possible outcomes. For example, implementation of health care standards was seen as a route for demonstrating effective governance:

'You can demonstrate effective governance through the application of Healthcare Commission standards. So if you're applying appropriate public health standards which apply to all NHS bodies, then you can demonstrate good governance.' (DPH, Phase 1)

Public health governance was described as embedded in the governance arrangements of the organisation. Additional structures would be superfluous and could serve to isolate public health which, some argued, had become disassociated from the health care agenda. In line with this, the concept of 'public health governance' was questioned by a number of interviewees:

'Well no, I think the phrase is unhelpful - public health governance. I think it is because in PCTs you have an integrated governance approach, you know, so you have integrated systems of direction and control, and dependent on what it is certain people either lead it or control it or monitor it or assure it.' (Deputy Chief Executive, Phase 1)

There was therefore less discussion by PCT interviewees of the governance implications of working across a local public health system than by focus group participants.

4.1.3 Governance failures

Lack of governance within organisations could be demonstrated where the purpose of the organisation was not reflected in delivery. However, performance management frameworks did not necessarily support a health and well being agenda. In contrast to process-related targets such as access, outcomes were difficult to quantify or measure and were not under the control of a single organisation. A Director of Strategy noted:

'No, I think the biggest problem the whole system faces is 'are we measuring the right things', that's the biggest failure of the system. How can you have governance if you're not even measuring the right thing?' (DS, Phase 1)

Focus group participants highlighted a wide range of 'governance failures' including: lack of clear accountability for the persistence of health inequalities; not making the case with the public for investing in public health priorities; a lack of due diligence and timely action across a public health system on hazards, such as alcohol, obesity or debt; lack of a proactive approach to local environmental risk; failure to identify public health consequences of policy decisions; and a narrow approach to effectiveness. Performance management arrangements were described as ill-aligned, focused on specific organisations and weighted towards national priorities and targets. A further issue was the underlying downstream approach to public health which worked against a stewardship role. One participant described it as follows:

'The implicit model is we will allow unhealthy social systems to generate disease, but buy it back at the cost of a public health programme. And of course you never get out of that cycle ..., and then efficiency in public health is seeing how quickly can we buy this back, what we've just lost, through a decision not taken here, or a view not balanced there.' (Regional focus group)

There were related concerns over lack of 'due diligence' in acting on emerging public health hazards:

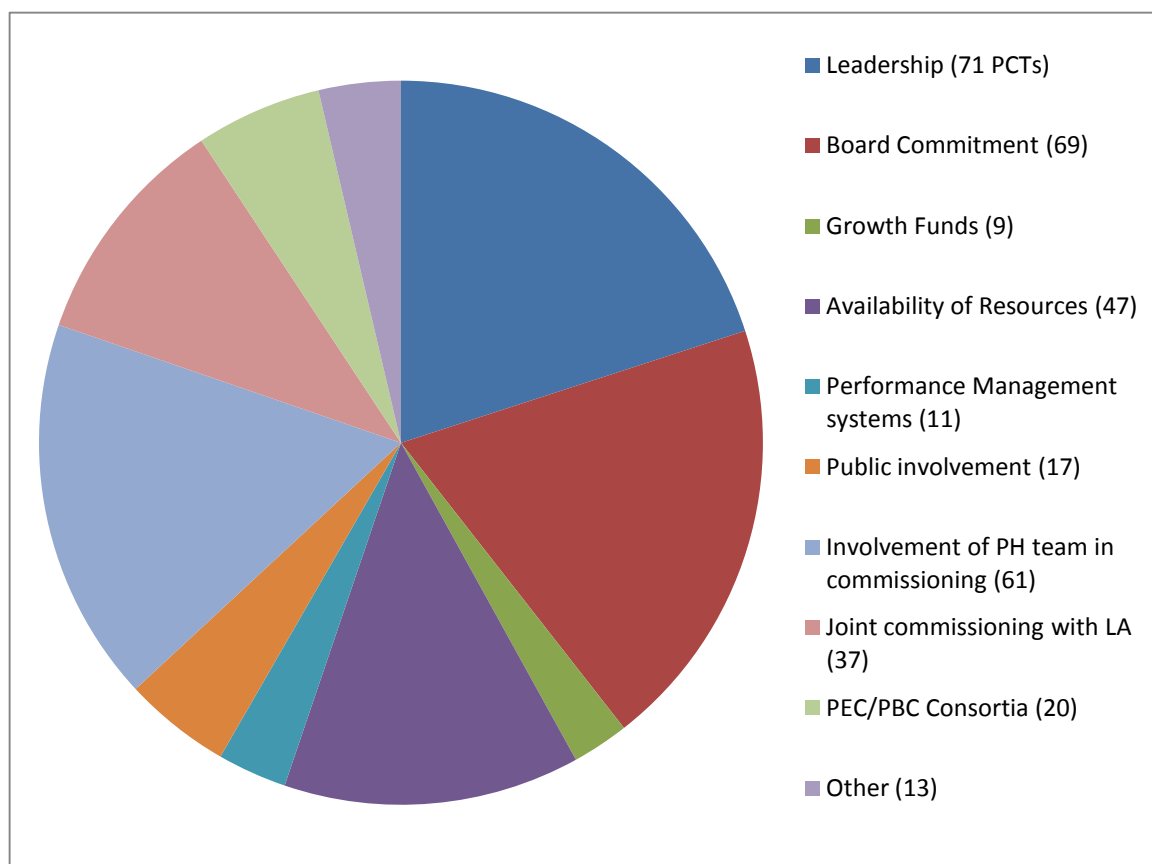
'And that's the bit of public health that's been consistently lost, despite the fact that from what we know had we addressed alcohol, five to ten years ago, we would not be in the position we are now, having lost all the gains from the clinical investment.' (Regional focus group)

A further governance failure was the lack or inappropriate use of evidence and lack of clarity over how to coordinate strategies across different agencies. It was considered that the public health evidence base was skewed towards clinical work. NICE provided guidelines on interventions and programmes but not on policy and strategy, challenges arising from a public health system or the consequences of public policy on health.

4.1.4 Enabling a health and well being agenda

The national survey demonstrated the role of leadership and board commitment as the two most important factors in enabling the health and well being agenda (see Figure 1).

Figure 1. Enablers for commissioning for health and well being



This finding was reflected in focus group discussions and interviewee accounts. In six sites, leadership of the CE and the DPH was considered key to ensuring that public health priorities were reflected in processes of governance. It was argued by some interviewees that stewardship formed an integral part of the public health role which included responsibility for safeguarding, anticipating and addressing risks. In two PCTs, the application to public health of the systematic approach familiar in clinical governance was discussed. For example, one interviewee stated:

'So it would be quite interesting to say take what we apply to clinical governance and debate whether you have the same thing in public health. So do you have people clearly in charge of it, have we got the right training courses so our staff are appropriately skilled, have we got the right processes that will get the right bits of public health in the right order. Does the board pay significant attention, does it receive the appropriate reports at the appropriate time. So it would be quite an interesting line of thought.' (Assistant CE, Phase 1)

This was reiterated by an interviewee in a different site, who commented:

'I think ... something about the failures in public health governance is that for so long public health has just been off the radar that any governance of public health is good because at least it shows that there's something to govern, if you like.' (DS, Phase 1)

PCT interviewees (13 interviewees from 8 PCTs) emphasised the stewardship role of the PCT Board in enabling the integration of health and well being into the strategic plan and commissioning cycle. One participant noted:

‘Our non-executive directors on the board are very much focused on the whole health inequalities agenda and, again, as part of that board they’re a very crucial part of ensuring that we keep on that line and, you know, there is no doubt the whole health inequalities agenda is now running through the organisation like the words on a bit of rock’. (DF, Phase 1)

Public accountability as a key dimension of effective stewardship was more prominent in the definitions put forward by members of OSCs for Health, members of the VCS and Board Chairs, as reflected in the following:

‘But I suppose a really good governance success would be if people felt that they understood how the PCT was spending its resources..., I mean actually wanted to engage with us on particular aspects of the public health agenda’. (PCT Board Chair, Phase 1)

They argued that there should be greater involvement of the public and the VCS in commissioning for public health outcomes; more transparency in the decision-making processes of commissioners; and a proactive approach to scrutiny. Successes in health stewardship could be demonstrated through an appropriate balance of investment across prevention and health care services; pan-borough scrutiny exercises to identify common issues within a local authority area, greater accountability to the public and making health part of the wider agenda.

There was less discussion amongst interviewees than focus group participants of changing notions of stewardship, due diligence or the governance implications of the stewardship role across a local public health system.

4.2 Practice-based commissioning and the stewardship role

Practice-based commissioners interpreted the stewardship role in different ways: providing continuity in primary care; financial stewardship; not destabilising the local health economy; and reducing health inequalities. While some interviewees were clear about the public health role of general practice and the potential of practice-based commissioners to commission health and well being services, others were concerned over the medicalisation of health arguing that many health and well being services were better located outside general practice. While PBC had a responsibility for maximising the use of resources, this required specific skills and raised fundamental tensions, described by one PBC lead as follows:

‘I mean as a consortium we’ve got in theory £160m to spend to improve the health of our population. Well, if we sit down and said what will we do with £160m, we probably wouldn’t do everything that we’re doing at the moment, but I don’t think we’ve got the time or the expertise up to now or the level of sophistication to understand how we can unpick what we’re doing at the moment and do something more effective ... this bit of tension between the health care intervention for the individual and the health improvement intervention for the population, and I think it’s that that we probably will continue to struggle with.’ (PBC lead, Phase 1)

It was argued that their training predisposed GPs to focus on individual needs rather than on population needs, the wider determinants of health or where they could make the greatest impact on health gain for their practice populations, acting as either commissioners or providers. One PBC lead commented on this as follows:

'Do they have access to the necessary public health skills? Are they going to take responsibility for the whole population and health improvement across the whole population and the partnership work that that engenders and particularly in relation to the wider determinants of health? And I think when you set it up like that the answer's no. They don't have the skills, they don't have the time, they don't have the leadership and they don't really have the will. And so my view is if you're going to set something up to fail then this is the way to do it.' (PBC lead, Phase 1)

Moreover, while financial balance was important, the stewardship role for clinicians was focused on the needs of individual patients, described by one PEC chair as follows:

'So the financial balance, I understand why the government needs it to be the be all and end all, but it's not the be all and end all for clinicians by any means; being able to improve the lot for our patients is the most important thing.' (PEC Chair, Phase 1)

It was argued that practices still largely thought of themselves as providers wanting 'freedom and flexibilities' and new business opportunities. As the health care side of general practice had expanded, GPs needed to be highly motivated to focus on prevention. A Director of Finance noted:

'They know that there are all these things that cause ill health but actually they're paid primarily to be a general practitioner. So unless they're really motivated to take time away from treating patients to go and do some of the other stuff, and they'd have to be really motivated to do that. They get well paid for treating patients.' (Phase 1)

In most sites, the involvement of PBC with the wider health and well being agenda was not well developed with the emphasis largely on demand management and prescribing. A Non-Executive Director commented:

'Well theoretically you would say that they were heavily involved. In reality, I would say it's fairly minimal. I would say that most family doctor practices see health and well being as a public health issue that's beyond their scope, and unless they're funded to get involved with it like providing screening for cardiovascular risk or providing long-term condition management for diabetes then I think most of them would see it as outside of their particular role.' (NED, Phase 1)

However, there were exceptions both between and within sites. In one site, for example, one PBC consortium was involved with local health and well being partnerships, but others were not. As discussed in Chapter 6, in a few sites there was greater engagement of practices with locality-based commissioning and local partnerships.

4.3 The impact of World Class Commissioning

WCC was seen as a route to effective stewardship through the systematic implementation of a strategic plan to promote health and well being through the commissioning cycle. It was argued that WCC was premised on a public health model:

'And I'm finding that doors that perhaps were a bit shut are starting to open because people are seeing the value of public health in world class commissioning terms. You can't just do cost and volume contracts any more. You've got to go down to the value and the efficiency and the effectiveness of your contracts, and that is public health. I mean you can't get away from the need for a public health analysis of these things even if you wanted to.' (DPH, Phase 1)

However, issues were raised over the extent to which public health perspectives were embedded into each aspect of the commissioning cycle, whether there was adequate public health input into PBC and the impact of different definitions of health and well being. These are discussed in turn.

4.3.1 Public health and the commissioning cycle

It was argued that the commissioning cycle should be public health driven and this should be reflected in contract specifications and performance management through the contract (further discussed in Chapter 8). A public health model would inject a population perspective into care pathway development, shifting the focus of commissioning decisions away from 'decision trees for treatment' towards preventive services.

In phase one, interviewees from six PCTs considered that the 'silo working' of public health, had been a barrier to commissioning for health and well being and PCT interviewees described a restructuring of roles and responsibilities to align with the commissioning cycle and encourage matrix working. This could result in a more influential role for public health through, for example, a fusion of strategic and public health directorates. In two case study sites, public health was described as at the heart of this process:

'We don't have a Director of Commissioning because that's what the organisation does ... and we've broken commissioning down into its component parts. And when we looked at what strategy and planning was all about in terms of that part of the commissioning cycle... well that's what Public Health teams do.' (DS, Phase 1)

In another site, it was argued that public health resources were limited and it was a question of where they could be used most effectively.

'I think yes, you could look at it both ways. I mean you could look at it and say well actually why is public health not being more actively engaged in core mainstream commissioning, or you could say actually there's a limited public health resource and where do we want to put the emphasis ... a fundamental part of our role is to get resources out of traditional commissioning and into lifestyle services. And so to some extent I think we have a role there in terms of questioning it but I don't think that means that we need to sit on each commissioning group.' (DPH, Phase 2)

Half of the sites considered that the emphasis on health and well being was reflected throughout the commissioning process; four sites commented that shifts in emphasis were underway while one site had been largely focused on financial recovery. In one site there was a consensus of views across all groups of interviewees that health and well being was strongly embedded in the work of the PCT and local partners.

4.3.2 Public health input into practice-based commissioning

There was variation in the extent to which public health teams worked with practice-based commissioners and some concerns from PBC that public health prevalence data, based on electoral wards, did not align with data on practice populations. In six sites, there were close links between public health teams and PBC consortia, described as follows by a PEC Chair:

'Each of the clusters gets a Public Health input where a representative of Public Health comes and does a report and says this is your cluster as we see it. This is where you're good, this is where you're not so good, this is what your premature death rate is compared with average ...And each of the clusters gets that input as well, which I think has enabled us to look at things slightly differently.' (Phase 1)

These findings were reflected in the national survey where 83 per cent of respondents said there was involvement from public health specialists with PBC consortia/clusters. For a small number of respondents this took the form of making available public health data to cluster boards. For the majority of these respondents, however, PBC clusters had direct public health support from designated consultants and specialists who sat on their boards or who covered several different clusters, or through public health involvement with PBC leads within the PCT.

4.3.3 Changing discourse on health and well being

While PCT commissioners identified a stewardship role with a systematic approach to the commissioning cycle, analysis of both first and second phase interviews showed that 'commissioning for health and well being' was interpreted in different ways both within and between sites. Definitions included the following:

(i) Public health values were mainstreamed and led all phases of the commissioning cycle. Public health values pervaded decision-making processes and were not seen as a preserve of a public health department. One interviewee commented:

'The worst thing in the world is to see commissioning for health and well being as being primarily a public health role. That's the worst thing in the world; it's got to be the bread and butter of commissioning, mainstream commissioning.' (DPH, Phase 2)

(ii) Commissioning 'upstream' through partnerships and through preventive services. Some interviewees were clear that commissioning for health and well being was about focusing upstream and one interviewee further distinguished between 'health' and 'well being' (happiness), given that 'the social gradient for health was not the same as the social gradient for well being'. The drivers for well being were more elusive. Some considered tackling geographical health inequalities as key, while others focused more specifically on healthy lifestyles and commissioning interventions related to smoking cessation, reducing obesity or promoting exercise. Multi-agency approaches were also highlighted.

(iii) Commissioning public health services (although the boundary between preventive services and treatment services was not always clear).

(iv) A strap line for all activities related to commissioning and procurement, spanning both prevention and acute care and the patient experience described, for example, as 'the total business of this organisation'. This was the case in over half the case study sites.

The ambiguity of the phrase was noted by a few interviewees and health and well being could be interpreted differently across different groups. For example, while it was argued that there was more interest from GPs in encouraging healthy lifestyles and increased public health involvement with PBC clusters, one DPH argued that general practice had a limited appreciation of the health and well being agenda:

'There's a barrier which is around a lack of understanding about what the well being agenda is about. ... there's still quite a large element of general practice that views public health and well being in very traditional terms as being about the kind of old fashioned health promotion and public health campaigns with posters on the walls and adverts telling people to do this and not do that and handing out leaflets at general practices and in pharmacies. And whilst that undoubtedly has a role it's really only a very, it's only a part, and you could say a small part of the way that we would want to go about health improvement in the City. So there is a barrier about their lack of a real understanding about the way that we want to address a health improvement agenda.' (Phase 1)

Another DPH argued that there was an advantage in including both 'health' and 'well being' as it kept the preventive agenda alive:

'It keeps the preventative aspect on the agenda. You know, because it forces people to define health as opposed to health care. Because, you know, that's the danger if you're commissioning for health, then people will just think health services and then health care, whereas health and well being reminds them that it's much more than that.' (DPH, Phase 2)

However, ambiguity also had its dangers. If everything was defined as health and well being then there was risk that a focus on prevention would be lost and reduced funding for preventive services could be masked. One DPH described it in these terms:

'I think what's happened in the last year, in particular, and the current financial forecast for the NHS has made us very much refocus on NHS services again, and in a way it's to the detriment of some of the partnership agenda that we were exploring through our public health roles in the organisation... now it's a very tight NHS focus and getting much more efficiencies out of the NHS, and it may well be to the detriment of broader Public Health programmes I think.' (DPH, Phase 2)

In summary, stewardship of the health of the population was seen as emerging from effective implementation of the commissioning cycle and a recognition of the complexity of governance for public health. However this was complicated by changing notions of stewardship and different interpretations of health and well being. Differences between sites in the extent to which commissioning reflects a public health ethos are likely to become more significant as the need to make savings makes it more difficult to invest for health in the longer term. There was a possibility that economic stringency would mean that the focus of commissioning for health and well being would become redefined and narrowed. This could be reflected in how the stewardship role was being understood within local organisations.

5 Governance in PCTs

This chapter is concerned with the impact of governance structures on commissioning for health and well being in PCTs with particular reference to the framework of standards, targets and regulation which shapes governance activities. Research questions include the extent to which this framework serves to prioritise health and well being in practice and the alignment of performance management regimes across organisations. The chapter begins by outlining the background to governance arrangements in PCTs (5.1) and describes standards (5.2) and targets (5.3) for health and well being which obtained at the time of the study, reviewing the extent to which such performance management regimes were seen as barriers or enablers for the health and well being agenda. The impact of changes in regulatory arrangements are then discussed (5.4) followed by the impact of WCC, introduced during the period of the study, as an additional performance management framework for PCTs (5.5). Appendix four includes further detail on standards and targets related to health and well being, including the WCC framework.

5.1 Governance arrangements in PCTs

PCTs have complex processes for governance and assurance. There are often separate committees for clinical, corporate and information governance but separate governance areas are increasingly organised within a framework for integrated governance, intended to streamline different systems and improve accountability. Governance arrangements are shaped by the range of audit and performance management activities which address the demands of independent regulators and by national guidance and policy priorities. They also serve to identify and monitor risks to delivery and reflect the statutory duty of PCTs to maintain financial balance. A key assurance framework for NHS organisations is that of clinical governance, described as the 'primary quality assurance framework' for NHS Boards⁷⁰ and incorporated into broader governance frameworks.⁷¹

PCT Boards have collective responsibility for performance and are accountable to DH through SHAs, to parliament through independent regulators and to local populations through OSCs. Accountability for contributing to partnerships and shared targets was assessed at the time of the study through the annual CAA. It has been argued that assessments through the Annual Health Check by the former Healthcare Commission, and since April 2009, through the CQC are considered key to 'good governance'.⁷² However the WCC assurance process proved increasingly influential over the course of the study, shaping the governance structures of PCTs as commissioning organisations.

Despite the key role in governance accorded to PCT Boards, Abbott et al.⁷³ note that strategy was crowded out by policy implementation and public health formed one of the low frequency topics for Board discussion. The

authors argued that Boards should be understood not primarily as accountable bodies but, in line with the analysis of Rhodes⁷⁴ in his discussion of the shift from government to governance, as forming part of a policy network, that is 'a mechanism whereby multiple agendas and accountabilities are negotiated within and across organisations and interest groups'.

5.2 Standards for health and well being

Standards for health and well being are included as part of the following: National Service Frameworks (NSFs), which followed the White Paper *The New NHS, modern, dependable*;⁷⁵ separate national topic-based strategies (such as the obesity strategy);⁷⁶ and core standards (assessed annually at the time of writing through the Annual Health Check). However there is sometimes a lag between the identification of public health problems and the development of national strategy. It has been pointed out, for example, that the national strategy for obesity did not appear until 2008 and the target for obesity, set in 1992, was dropped in 1997 and did not reappear as a PSA until 2004.¹³

NICE public health guidance informs implementation of the NSFs and a number of the standards; it also provides guidance for evidence-based interventions and implementation strategies of local partnerships. The NHS has a legal obligation to meet NICE guidelines. The guidance is developed in the context of a broad conceptual framework for public health.⁷⁷ However, the evidence base is underdeveloped as a basis for decision-making and prioritisation. Public health guidance often lacks the specificity of clinical guidance and this is particularly the case in relation to wider determinants of health. This point is returned to in Chapter 9.

NSFs include measurable goals and are updated and reported on (although at variable intervals). Many of the NSFs include preventive components, for example, standards one and two of the NSF for coronary heart disease relate to reducing heart disease in the population and reducing smoking. Progress reports on NSFs and some monitoring activity was carried out via the improvement reviews of the former Healthcare Commission, for example on tobacco control,⁷⁸ sexual health services,⁷⁹ and diabetes.⁸⁰ However, NSF recommendations and milestones for prevention are not routinely prioritised in the performance management system.

Currently, public health occupies a separate (seventh) domain in the Annual Health Check but public health aspects of the other domains, such as governance, are less well developed. Public health is also less reflected in the core than in the developmental standards, which are no longer assessed. The Annual Health Check was considered a key assurance process by PCT interviewees. Accounts of the impact of NICE public health guidance and the economic evaluation of public health interventions are discussed in Chapter 9. NSFs did not emerge as a separate influence and were rarely mentioned by interviewees.

5.3 Targets and performance management regimes

Changes in targets and performance management regimes since 2007 were intended to promote a more streamlined approach to assessment and regulation, a better alignment of performance regimes and a more flexible approach to choosing local targets. There were changes in three year PSAs, in LAAs and in the AOP for the NHS. A large number of indicators remains, often in the form of sub-indicators or performance objectives under headline targets. There are 157 indicators for the 30 PSAs⁸¹ plus 'legacy indicators' and each organisation has targets of its own. Local authorities are also monitored on all 198 indicators of the new National Indicator Set (NIS).⁸² Research carried out by the Institute for Government³⁴ showed that some targets were widely considered unachievable within a three year time frame (such as reductions in All Age All Cause Mortality (AAACM), others were difficult for some areas to achieve (such as teenage pregnancy), baseline data were often lacking, and some indicators were unclear or poorly designed. It was also difficult to prioritise across different targets. Splits were described between strategic priority-setting through the Sustainable Community Strategy and the process for deciding LAAs. Moreover, despite being intended as a route for local autonomy and devolved control, some saw statutory LAAs as further examples of top down control, with less room for manoeuvre than anticipated.

Interviewee accounts of performance management regimes are discussed following a brief summary of targets.

5.3.1 Public Service Agreements

Thirty PSAs emerged from the 2007 Comprehensive Spending Review (CSR).⁸³ PSAs 12, 18 and 19 are of particular relevance to health and well being (see Appendix 4). The national inequalities target formed part of the PSA for 2002, 2004 and 2007 and was reaffirmed as part of PSA 18 where AAACM is used as a proxy measure for the life expectancy element of the target, although the 2010 national inequalities target, with its emphasis on narrowing the gap, also remained in force. AAACM is also reflected in the NHS Operating Framework²² (see Vital Signs, below) and as part of the NIS (see below), as indicator N120 in the category 'Adult Health and Well Being'. Reducing health inequalities and increasing life expectancy are mandatory health outcomes for all PCTs as part of WCC. Encouraging partnerships is built into the structure of LAAs and PSAs and reflected in assessment procedures.

5.3.2 The National Indicator Set and Local Area Agreements

The 2007 CSR also announced a new NIS for local authorities and local authority partnerships. From 2009, the NIS was used to monitor the performance of local authorities and partnerships through an annual CAA. LSPs choose 35 locally appropriate targets from the NIS and may also choose additional local targets, in line with the findings of local JSNAs. Targets are negotiated with Government Offices. LAAs, a vehicle for

commissioning health and well being across partnerships are now statutory and rolled out across England. They are the delivery mechanism for these targets and achievements are rewarded through an area-based grant thus giving local councils more control over how to distribute funding. The focus on LAAs underlines the importance of the joint setting and delivery of targets and of partnership working to deliver better outcomes in both health and social care. However, there are discrepancies across LAAs and WCC health outcomes. For example, a reduction in AAACM is a mandatory outcome for WCC and all PCTs, but an analysis of priorities reflected in LAAs shows that this target was adopted by only 88 LSPs.¹⁵ This could indicate that this key indicator was often perceived as an NHS issue.

Interviewees and focus group participants expressed optimism over the potential role of LAAs to make public health a shared priority for wider partnerships and to shift the focus away from the current emphasis on organisational governance towards partnership governance focused on a local area. However, LAAs raised issues of accountability for achieving health outcomes and concerns were also expressed that they could become reduced to debates about indicators and the process of measurement:

'I think there's been so much top down effort put into them, that they're almost guaranteed to be delivered by the time that they're actually put in place, and therefore it just feels like a grant condition, rather than actually something which is genuinely owned.' (National focus group)

Despite policy intentions to reduce the number of national targets, and focus on targets which were locally relevant, there was pressure to include specific targets and measures in LAAs, some of which were considered unachievable. Tensions remained between national targets and local priorities and the inability to target investment at local problems. However, where they were locally relevant, LAAs could provide a spur to local action:

'No one really cares how we do in relation to someone else but in the city, the councillors, everyone else, are thinking about their relevance to local people, you do care about that and also you live there and that affects how you think of your city as a place. That drive to localism is a really powerful governance lever.' (Regional stakeholder)

5.3.3 Vital signs

The 20010/11 AOP for the NHS in England²² continued to adopt 'Vital Signs', first introduced in the 2008/09 operating framework,²¹ as the basis for assessing health outcomes and health care. There are five headline priorities: improving cleanliness and reducing health care associated infections; improving access through the 18 week referral to treatment pledge and improving access to GP surgeries; keeping adults and children well, improving their health and reducing health inequalities; improving patient experience, staff satisfaction and engagement; and preparing to respond in a state of emergency. These are associated with 13 indicators.

'Vital signs' has a three tier approach: national headline priorities, as outlined above; national priorities for local delivery (associated with 17 indicators) where there is some flexibility about local targets; and local priorities associated with 33 indicators, although PCTs are not limited to

these (see Appendix 4 for details of indicators for tiers 2 and 3). Where there is overlap with indicators in the NIS these may also be pursued through a LAA and there are 31 indicators in Vital Signs which form part of the NIS. While local priorities are to be determined and set locally, in consultation with patients, public, staff, the findings of JSNAs and agreed with partners there is no performance management role through DH.

With the introduction of the NIS and 'Vital Signs' the Annual Health Check for 2008/09 included PSAs as set out in the 2007 CSR and Operating Framework as benchmark indicators to rate PCTs. It also included older targets set as part of the 2004 CSR, where targets were outstanding until 2010.

Despite attempts to streamline targets, it is questionable whether the target burden is reducing as 'Vital Signs' do not represent the whole picture. There is a range of existing commitments and previous priorities. Although there are financial penalties for failing to meet certain priorities, these do not apply to health improvement. It has been pointed out ¹³ that overlapping layers of standards and targets in health improvement over the last ten years, combined with inconsistent prioritising has led to some confusion. For example, fuel poverty was a priority in *Tackling Health Inequalities. Programme for Action* ¹⁷ but not included in the public health White Paper, *Choosing Health*.⁸⁴ There is also some confusion about the status of health improvement issues not included as PSAs. The relationships between PSAs, the NIS, Departmental Strategic Objectives and Vital Signs are complex, leading to attempts to map overlaps between them, further described in Appendix four.

5.3.4 Views of the target culture

Targets and performance management regimes figured prominently in focus group discussions and PCT interviewee accounts. Views of performance management regimes derive from PCT interviewees, as knowledge of them was limited amongst other interviewees, including practice-based commissioners.

The national survey provided an overview of the nature of support for health and well being. It asked respondents to rate how supportive each of the areas itemised in Table 5 were for the health and well being agenda. The percentages are the proportion of individuals who selected that particular rating. This demonstrated the relatively minor role played by various performance management regimes as compared with Board values, and the relatively greater role accorded to the LAA than the Annual Health Check.

Table 5. Support for the health and well being agenda

	Strongly support	Quite strongly support	Medium support	Weak support	Very weak support	N/A	Total responses
Board values	63.2% (55)	25.3% (22)	11.5% (10)	0	0	0	87
Current performance management systems	14.9% (13)	32.2% (28)	34.5% (30)	12.6% (11)	4.6% (4)	1.1% (1)	87
Financial allocations	23.9% (21)	17.0% (15)	12.5% (11)	18.2% (16)	26.1% (23)	2.3% (2)	88
Annual health check	16.1% (14)	34.5% (30)	26.4% (23)	17.2% (15)	5.7% (5)	0	87
Comprehensive area assessment	18.4% (16)	47.1% (41)	20.7% (18)	9.2% (8)	3.4% (3)	1.1% (1)	87
PBC priorities	8.2% (7)	24.7% (21)	22.4% (19)	35.3% (30)	9.4% (8)	0	85
PCT prioritisation methods	27.6% (24)	37.9% (33)	19.5% (17)	11.5% (10)	2.3% (2)	1.1% (1)	87
LAAs	20.9% (18)	57.0% (49)	19.8% (17)	1.2% (1)	1.2% (1)		86
Public involvement strategies	9.2% (8)	36.8% (32)	34.5% (30)	14.9% (13)	3.4% (3)	1.1% (1)	87

There was a range of views on targets, their benefits and limitations. Most commissioners considered performance management regimes as a driver for improvement, and interviewees from three PCTs commented on the benefits of Vital Signs for the health and well being agenda as the organisation could be held to account for delivery of health and well being targets. However, questions were raised over the extent to which indicators supported longer term outcomes, whether health and well being indicators were prioritised and over inadequate alignment across performance management systems.

A key criticism was that a short-term target culture could work against a stewardship role and assessing longer term risks to public health:

‘But the bit that’s missing is the kind of due diligence, the bit that in twenty years’ time ... they’d say why on earth didn’t you notice that and do something about it? And the answer of course is “it wasn’t a target”. Or “it wasn’t required of us”.’ (Regional focus group)

Focusing on targets could distract attention from overall prevalence or gaps in service provision, while the annual financial planning round discouraged a focus on improving health over the longer term in favour of investments where payback was more immediate:

'The problem we have at the moment in having to do the yearly cycle means that some of the things if they're not going to pay back within a year or two then you very quickly lose interest in investing in them because something that's going to pay back this year is actually going to be far more of a draw to the finance team.' (PEC Chair, Phase 1)

There was general agreement, expressed in seven case study sites, that the system was overloaded with targets. One interviewee noted:

'I think the problem is there's just so many of the blooming things. You know, there's so many vital signs, and no matter how many new initiatives we get, they add to the existing list of targets that we have rather than actually reduce them.' (DPH, Phase 1)

Others saw Vital Signs as a blunt tool, given that some of the data were out of date and the evidence base needed development:

'The data we're getting today is two years old, what are we supposed to make of that for current practice? I mean if they're serious about vital signs, what we need is a vital signs roadmap or route map that for each vital sign you have to have a suite of evidence-based interventions.' (DPH, Phase 2)

As demonstrated in previous studies,^{35, 54} not all targets were subject to the same level of scrutiny: despite national targets for narrowing the health gap, and an emphasis on reducing health inequalities in national guidance, this proved no guarantee for their being prioritised in practice. Over 80 per cent of PCT interviewees considered that their focus remained on central priorities: the control of health care acquired infections; an 18 week limit on referral to treatment time; Accident and Emergency waits under four hours; and the duty to remain in financial balance. These were reflected in performance management arrangements with the SHA as well as with external regulatory bodies and were non-negotiable. They also influenced spending priorities. SHAs were described as being largely focused on central priorities, which did not always align with local priorities and targets, LAAs or with the public health agenda. This was the case despite inclusion of health improvement targets in performance management systems:

'I think it's very frustrating that some of the high level targets around all-age, all-cause mortality, IMD, life expectancy are all supposed to be very, very important but actually when the Strategic Health Authority comes to visit they're mostly interested in 18 week waits ... I'm glad that we do have priorities for performance management, and I'm a real strong advocate for if they're the right targets then if we deliver on it we'll have the impact that we desire. But it does sometimes feel, as I said, like we've got them but actually people aren't particularly interested in them.' (DPH, Phase 1)

Moreover, electoral cycles predisposed to short-term targets, and only some targets were considered 'career limiting'.

'I just think the realpolitik is what am I going to get sacked over, failure to deliver smoking cessation or failure to deliver the 18 week target? When smoking cessation has the same value and priority as the other 152 targets then it'll get the same emphasis. Have you heard of a Chief Executive in the NHS being sacked for failing to deliver smoking cessation? Have you heard of them being sacked for failing to deliver 18 weeks?' (Director of Strategy, Phase 1)

Moreover, trajectories agreed with the SHA could prove unrealistic in practice. Two PCTs gave examples of challenging smoking cessation targets which had been met but without the trajectory being redefined.

Performance management regimes were also criticised by commissioners in eight case study sites for encouraging issues to be considered in isolation and, in particular, for focusing on process measures and activity rather than on outcomes. Measurement of processes was often appropriate for secondary care activity but raised a number of issues for health and well being. Links between processes and outcomes were not always clear: as one example, measuring progress towards meeting the target for four week quitters or 13 week quitters for smoking cessation was not a valid indicator of improved outcomes. Furthermore, processes for achieving the targets were not under commissioner control. One interviewee described this in terms of the AAACM target:

'Now, if you look at targets, for example, for All Age All Cause Mortality, it's very different because you can't manage the process of reducing All Age All Cause Mortality in anything like the same way that you can manage the process of waiting times for surgery. You know, you just can't say right well if we invest a million pounds in this it will bring it down by this much or if we invest a million pounds there it will bring it down by that much and therefore that's what we'll do. And the second thing is that even if you could do that and you reduced All Age All Cause Mortality which for men in [name] at the moment is somewhere around 600 per 100,000 population, supposing they reduced it to 550, would we want to reduce it further? Well yes of course we would because ideally we get it as low as we can.' (DPH, Phase 1)

It was argued that targets should be outcomes-based and influenced by clinicians and public health.

In five case study sites, and including the two highest performing sites, targets were viewed in a different light. It was argued that, for high performing organisations, targets should be a by product of culture, systems and processes, rather than the focus of endeavour. What lay behind the target needed to be understood in order to avoid 'hitting the target but missing the point'. Only by performing well against targets in general should organisations be given the freedom to innovate. As reflected in the discussion on prioritising investment in health and well being (Chapter 9), some interviewees also emphasised that the health and well being agenda was an 'earned agenda', dependent on the achievement of financial balance and delivering key targets. This was reflected across both PBC and PCT interviewees:

'Where you have a culture in performance, you keep financial balance, you deliver the targets and that's what gives you the platform from which to practice the public health agenda. ... (it) gives you the licence to do the rest.' (PCT Chief Executive, Phase 1)

The same sentiment was echoed by a PBC lead from another site:

'I mean well commissioning isn't that old anyway and therefore in the first couple of years of commissioning, you've got to go for the big hits really and prescribing and scheduled care alternatives to hospital for kind of outpatient-type procedures and surgery, these are all the obvious early areas of work. I think once you've got beyond that bulge, which has to happen first I think, then we certainly as a cluster have started to think on the health and well being strategy.' (PBC lead, Phase 1)

5.3.5 Views over alignment of performance management regimes

PCTs typically tried to achieve alignment across the range of targets, including WCC health outcomes, LAAs and Vital Signs but this was not always considered possible as NHS targets were not the same as LAAs. QOF targets also differed from PCT targets. There were challenges in achieving alignment across LAAs where PCTs spanned a number of local authorities. However there had been improvements in alignment across the regulators, as one interviewee commented:

'Eighty per cent of our time was spent responding to different external organisations which were asking slightly different questions and wanting all the different formats.' (Associate DPH, Phase 2)

It was argued that alignment was more evident at a strategic level than at the 'sharp end' of assessment. Concern over a lack of alignment across the SHA and Government Office was of concern to commissioners in all case study sites. One interviewee commented:

'So Monitor, the Care Quality Commission, the Strategic Health Authority and the Audit Commission, and they all have very, very different agendas, all of which impact on different bits of the health care and indeed social care system, and indeed more broadly into the sort of partnership agenda with comprehensive area assessment, and they are aligned in the very broadest most strategic sense, but when it comes to checking things at the sharp end, of course they don't join up.' (DS, Phase 2)

The existence of an intermediate layer of performance management, in the form of the SHA, was a major difference between the NHS and local government and this was reflected in difficulties over negotiating local targets. Lack of alignment between PCT and SHA priorities was seen as a barrier in five case study sites. Failure to integrate performance management regimes was commonly cited as a governance issue and reflected in difficulties in monitoring LAAs. One interviewee commented:

'I think the SHA struggled to understand the Local Area Agreement, have failed to actually integrate its performance management into their performance management systems and haven't even managed to turn on the Government Office computer that we can monitor our own LAA through... So it is not joined up, the LAA are monitored down the one side, and in fact we were filling CAA monitoring and LAA monitoring stuff recently, at the same time as filling in exactly the same forms, with slightly different data for world class commissioning outcomes - I mean what a nonsense, no integration across. No integration across Government Office and SHA.' (PCT Chief Executive, Phase 1)

Interviewees also commented on the lack of alignment between ambitious SHA indicators and targets and those negotiated with Government Office and reflected in the LAA. As a result PCTs often ended up attempting to renegotiate one common target where councils were unwilling to sign up to 'undeliverable targets' or working towards two different targets with dual reporting. It was pointed out, for example, that 'Vital Signs' trajectories were 'refreshed' at a different time to the LAA indicators which could create problems: one interviewee described how a range of targets could be related to one indicator, depending on whether it formed part of the LAA or of Vital Signs and this led to ambiguity which made it difficult to make progress against the target.

At a local level, however, there were joint approaches to performance management across PCTs and local authorities. In one site, some performance management staff were paid by the PCT but managed by the council so that a coordinated management process was in place. Some PCTs had developed web-based systems for monitoring strategic objectives, including partnership objectives which were shared with the local authority and which, it was argued, helped to keep a focus on the health and well being agenda.

5.4 Regulation and monitoring

PCTs are regulated by the CQC and the Audit Commission. Local monitoring is carried out through OSCs and LINKs. It has been pointed out¹³ that, internationally, the Healthcare Commission was the only regulator with statutory responsibilities to assess health care organisations in relation to public health delivery - a feature, it is argued, that has proved beneficial for local health improvement (p. 41). From April 2010, after a transitional year, the CQC replaced the Annual Health Check with a new system of provider registration and separate assessment of PCTs as commissioners, working more closely with other regulators. The focus is on quality of care measured across six domains of quality.⁸⁵

In its capacity as auditor of organisations which spend significant amounts of public money, the Audit Commission (though local auditors) assesses PCTs and produces the annual Auditors' Local Evaluation (ALE letter). Through the 'use of resources framework' (introduced in May 2008) auditors consider how well organisations are managing and using their resources to deliver value for money and better and sustainable outcomes for local people. The framework is structured into three themes: sound and strategic financial management; strategic commissioning and good governance; and the effective management of natural resources, assets and people. From 2009, the use of resources framework forms part of the CAA and other performance management frameworks. It also draws on the findings of the assurance process for WCC. Crucially, partners will be held collectively to account for their performance and the extent to which they achieve aims for the local area by main public sector inspectorates working more closely together, as opposed to the previous system of the Audit Commission performance managing councils through the Comprehensive Performance Assessment process. This would help assess whether investment was aligned with the needs of the community.

PCT commissioners from all sites commented on the CAA, which was viewed as potentially encouraging a focus on health and well being for non-NHS organisations, increasing the emphasis on health and well being within partnerships and reducing the tendency for health to be perceived solely as PCT business. Interviewees in three sites considered the assessment process would encourage partner agencies to work together for common outcomes. All partners across a local area would need to consider how their services could improve the health and well being of their local population:

'I hope it will have the effect of making the local authority more aware of its health and well being responsibilities and more willing to cooperate with the PCT in delivering those responsibilities. Clearly there's a very explicit focus in the Comprehensive Area Assessment on the way in which local organisations work together, so I guess it will make us consider that in more specific detail.' (DPH, Phase 1)

It was also argued that the CAA would focus on the overall impact of partnerships on the local population rather than on the performance of individual organisations. This would encourage a shift to partnership working:

'Everyone will realise that they're dependent on each other in a way that they haven't been before in terms of partnership working, in order to attain their rating that it will actually make people work together for the better... It will make partnership very much more real.' (OSC Chair, Phase 1)

Moreover the publicly available assessment results would be a useful resource, providing comparative information about services.

Some interviewees were concerned that the CAA could become an additional and separate burden and that it would prove difficult to meet the assessment criteria. Others argued that the CAA was perceived as council-led:

'Everybody at the PCT today will tell you in an instant what world class commissioning is, what their part to play is in it. Half of them wouldn't know what CAA stood for to be honest because it's not seen as relevant.' (DS, Phase 1)

Interviewees from the OSC and the VCS also questioned the extent to which the public or scrutiny committees would be involved, whether public views would be incorporated in the assessments and if the CAA would assess how well public agencies engaged with the voluntary sector.

5.5 World Class Commissioning as a performance management regime

Although originally a developmental process WCC² was considered an influential performance management regime and a key route for achieving improved health outcomes through encouraging a systematic approach to the commissioning cycle. The assurance system assessed PCTs against three core areas, governance, outcomes and competencies, described in more detail in Appendix four. Failure to meet minimum standards could result in further action being taken through SHAs, and in extreme cases, PCTs could be subject to a failure regime.

Interviewees from all case study sites considered WCC as an effective assurance process allowing PCTs to benchmark their progress. Interviewees in four sites felt that WCC had allowed the health and well being agenda to be taken forward both through a focus on health outcomes and a shift in the power between commissioners and providers:

'There seems to be a policy shift as a result of world class commissioning that pushes us that way because we will be performance managed and therefore incentivised on performance in relation to life expectancy, health inequalities and the suite of public health outcome areas that we've determined as part of our world class commissioning approach.' (DPH, Phase 1)

In two sites it was argued that WCC had not encouraged any extra emphasis on health and well being within their PCT as this was already well established. Organisational restructuring around the commissioning cycle in eight of the sites at the time of first phase interviews had encouraged matrix working and closer involvement of public health in the commissioning cycle, which was increasingly based on the JSNA. However, partnership commissioning processes required development and one interviewee questioned whether WCC placed enough emphasis on partnership working in commissioning for health and in working with local authorities.

PBC created separate governance tensions due to potential conflicts of interest arising from the combination of commissioning and provider roles and issues of alignment across PCT and PBC. One PEC Chair described it as follows:

'I mean I think practice-based commissioning, it's a mess. It's a hodge-podge. It's not at all what they call a Ronseal product. It's a confused amalgam of a whole load of different things that had guidance which was slightly unclear I think.' (Phase 1)

Some interviewees were confident that their governance structures provided effective firewalls between the two roles and, in four sites, interviewees considered PBC was making good progress. In one site, conflicts of interest had been addressed through an annual review with external facilitators and practices had set up their own provider company. In another site, however, there were clear tensions between what was perceived as central control by PCTs and the need for local autonomy. Nevertheless, a degree of alignment across PBC and PCT plans was generally achieved. As one interviewee commented:

'We've had to ensure that the commissioning plans that we've put forward can at least nominally be aligned to the various targets which the PCT has to meet. But I wouldn't say they were in any sense a driving force behind what PBC is trying to achieve.' (PBC lead, Phase 1)

Involvement of practice-based commissioners in the commissioning cycle was variable, consensus across consortia could prove elusive, and PBC was often seen as falling outside the commissioning cycle, unaware of PCT priorities, WCC competencies, local partnerships, demands on PCTs or QIPP:

'There aren't clear commissioning principles embedded into the practice-based commissioning process, although there are in the PCT process. So that's the problem.' (PBC lead, Phase 2)

And from another site:

'I have to say at the moment that recognition of the World Class Commissioning competence framework amongst practice-based commissioners is pretty low. I mean I'm sure they, I think they probably now know what we're talking about.' (DPH, Phase 2)

Interviewees raised a number of skills deficits: practice-based commissioners needed skills in commissioning on a larger scale and in more complex areas; developing strong business cases; having increased understanding of the larger strategic picture and the broader health agenda; and understanding how to commission from wider partnerships.

However, this was not the case in all sites and a few PCTs described active PBC consortia informing strategic plans, and acting as a driving force. In other sites they mainly provided an important communication link between practices and the PCT.

Before the introduction of WCC in 2007, *the Commissioning Framework for Health and Well Being*⁷ noted that incentives did not yet 'fully support the delivery of better health and well being', that skills for forward looking commissioning and focusing on prevention were scarce and that health and local authorities were 'structurally complex and culturally different organisations' (para. 1.12). At a local level, there is evidence that the complex system of targets and regulation which frames priority-setting within commissioning organisations, imperfectly translates government intentions for promoting health and well being. Problems of complexity, lack of alignment of targets across agencies, an emphasis on short-term process variables and an unspoken hierarchy of targets combined to ensure that an emphasis on health and well being largely exists in spite of rather than as a result of performance management frameworks. Nevertheless WCC was seen as a counterbalance, combining an outcomes-based approach with a systematic process underpinned by commissioning competencies. The test would lie in the extent to which this framework led to changes in delivery.

6 Governance between organisations

Working through partnerships is considered key to improving health and well being, although it is recognised that strong partnerships with well-developed performance management arrangements are needed.⁸⁶ This chapter begins by outlining the policy background for local partnerships for health and well being (6.1) and then discusses interviewee accounts in relation to the following key themes: views of partnership (6.2); partnership working in relation to the JSNA (6.3); joint DPH posts (6.4); and joint commissioning arrangements (6.5). The chapter concludes with views from second phase interviewees on the impact of the economic climate on partnership working.

6.1 Policy context

An emphasis on partnership working at a local level is reflected in the Annual Health Check and in the WCC assurance process (through competency 2). It is fundamental to the CAA and reflected through the agreement and monitoring of LAAs. It is also reflected in national policy initiatives for joint working such as 'Total Place', a whole area approach to public services,⁸⁷ integrated care pilots; and integrated working under the aegis of statutory Children's Trusts. Bernstein et al.⁸⁸ reiterate arguments for an integrated commissioning model for health and well being commenting that:

'The specific roles of primary care and different sectors of the NHS, social care and other local authority services, and other public sector partners are key in ensuring effective delivery, as is the role of local area agreements and other partnership arrangements in supporting integrated action on health and well being. We envisage this integrated commissioning model being driven by local strategic partnerships, with localised health and well being strategies and delivery plans being developed in response to local needs.' (p.8)

LSPs and their themed sub-groups are responsible for delivery of the Sustainable Community Strategy and therefore for many areas of health and well being. They have been described as a key governance structure 'highlighting and resolving cross departmental and cross-agency conflicts'.³⁴ While they are not statutory organisations (although there is a statutory duty of partnership), lines of accountability are to the respective organisations making up the partnership while, at the same time, there is horizontal accountability across the partnership as a whole. Despite the original intention that LSPs would simplify local partnerships, there are complex accountability arrangements between LSPs and local authorities and between VCS members of LSPs and the organisations or community networks they represent. Cutting across these organisational accountabilities are tensions between participatory styles of decision-making and accountability based on local democracy.⁸⁹ These difficulties are likely to be compounded by tensions between different national policy priorities, such as affording greater choice to consumers while at the same

time reducing inequalities, or by the creation of performance management systems which undermine local priority-setting.

Johnson and Osborne⁹⁰ showed that, despite a framework designed to combine coordination of activities through LSPs with co-governance, the former was supported through a range of processes including funding, target setting and accreditation, while the latter was neglected. Partnerships at a local level are also influenced by a lack of cross-departmental working at national level. A report from the Institute for Government ³⁴ noted that:

'Incentives for Whitehall to work cross departmentally remain weak. There is virtually no pooling of resources to support cross departmental policies despite the fact that central government itself recognises that such pooling is a powerful incentive for partners to work collectively and to make the necessary trade offs between conflicting priorities.' (p.10)

We explored views of partnerships and partnership governance through focus groups and the views of interviewees, and also addressed related topics such as the JSNA, joint posts and the CAA.

6.2 Views of partnership

All study sites had a health partnership sub-group of the main LSP which generally included representation from two or more VCS organisations, (although not always the same groups as were represented on the main LSP). All groups of interviewees recognised that promoting health and well being required working across agencies to address the wider determinants of health. Partnership working was emphasised by approximately two thirds of PCT interviewees, all VCS and the majority of OSC interviewees as an important factor in commissioning for health and well being and improving health outcomes over the longer term:

'And there's issues around improving lifestyles which will help in the shorter term and that's partly within the gift of the health services and partly within the gift of partners ... As you get into the longer term, it's around working with local authorities to get regeneration into there and get employment opportunities, improve educational attainment, get the right kind of levels of training and education for people to take the jobs that would come into the area.' (DPH, Phase 1)

The areas of partnership working discussed by interviewees differed according to their role. While PCT commissioners and the VCS discussed governance, partnerships for health, barriers and enablers for partnership working, practice-based commissioners largely focused on partnership working with the PCT. They also discussed the involvement of partners in reconfiguring services or in managing demand, reflected, for example, in the inclusion of social services in care pathway redesign. The following sub-sections discuss accountability arrangements and levers and barriers to partnership working.

6.2.1 Accountability arrangements in partnerships

Partnerships reflected different kinds of accountability: partners were accountable to partnerships as well as to their respective organisations; local authorities also had a democratic mandate; community participants

sought to reflect a diverse VCS; and there were complex arrangements across the various themed sub-groups. Focus groups and interviewees discussed partnership governance, including ways of monitoring and evaluating initiatives across partnerships, ensuring that governance between organisations met agreed criteria and creating clear accountability arrangements. However, it was argued that arrangements for partnership governance lacked clarity given different systems of regulation in local authorities and it was argued that public health targets were less rigorously monitored.

One of the major barriers to partnership working was the emphasis on 'single organisational success', which was reinforced in governance mechanisms. Governance structures for health and well being were unclear at the interfaces of interagency working:

'But actually, you know, when it comes down to the inter-agency bit, all those systems seem to collapse ... And that seems to me the territory that public health is in, you know, that's where public health governance is, and actually we haven't solved the governance system there.' (National focus group)

Whilst PCT interviewees generally viewed PCT governance mechanisms as robust, partnership governance was considered less developed:

'But there's also I think big questions around integrated and partnership governance, whereby where we're making joint investments in quite a lot of things. I'm thinking around children's services as a for instance. That currently as I said earlier is tracked separately through our own boards and through our own corporations... there's a kind of issue around satisfying and continuing to satisfy our own organisations and the regulatory bodies that currently exist but also doing it also in a more integrated way.' (PCT Chair, Phase 1)

A Chief Executive went further in his criticisms of partnership governance:

'I've never yet seen an organisation that can list all its staff that attend the relevant, even the statutory partnerships, that if a partnership agrees the strategy do they then work out the implications for each organisation? Does that implication get communicated back to the organisation.... Having agreed it how do others then hold them to account? And if you're running a shared target through it how do we hold somebody else to account for their bit? And I've never yet come across anyone or any place that can give me clear answers to those sorts of questions, so I think there is a major weakness about this, about partnership governance that needs to be better addressed than it is at the moment.' (Phase 1)

Accountability arrangements between partnerships and their sub-groups could also create difficulties. While health partnerships had developed terms of reference for working within their partnership with accountability to the LSP, links between sub-groups did not reflect the cross-cutting nature of the health and well being agenda. Concerns were expressed in by VCS interviewees in all case study sites that themed partnerships under the LSP could work against a whole system approach:

'Well in terms of commissioning, commissioning is largely done with a relatively narrow focus. So there's little in terms of cross-cutting agenda commissioning with this holistic approach in mind, it's very much on specific service delivery. So there's too many opportunities for duplication and lack of coordination.' (VCS, Phase 1)

One of the consequences of governance complexity was an emphasis on local leaders with the skill to understand and negotiate a wide range of governance arrangements.

6.2.2 Levers and barriers to working in partnership

Partnerships for health and well being were encouraged through good working relationships, the introduction of the CAA, jointly agreed LAAs and the WCC initiative. However, a number of barriers to effective partnership working for health and well being were also identified.

First the breadth of the health and well being agenda made it difficult to engage with, as one interviewee noted:

‘Because certainly the discussions we’ve had at local strategic partnership level has been actually health and well being is so all encompassing that there’s a tendency for everybody to go it’s not my problem.’ (DS, Phase 1)

In one site, it was argued by PCT interviewees that the local authority saw the PCT as responsible for health promotion and prevention services with other partners responsible for social care and wider determinants. In two sites it was argued that local authority and PCT had different approaches to this agenda and, despite joint appointments, the influence of DsPH on the local authority agenda was limited. This is further discussed in sub-section 6.4 below.

Second partnerships and governance arrangements were prey to constant change through reorganisations and shifts in the political agenda and this had proved a barrier in three case study sites. A PEC Chair commented:

‘And every time you have a shift of structure, you have to reorganise your governance structures, which potentially undermines those structures. Because governance is around having a clear idea of what you’re measuring, how you’re measuring it, and making sure it’s safe and effective. You get that in place and then say oh no, no, we’re reorganising it all So I think every time you have a reorganisation or a restructure, not that they shouldn’t happen, I think it potentially undermines governance for some length of time.’ (Phase 1)

Moreover the reorganisation of PCTs had led to a loss of locality focus which was considered a retrograde step, breaking up partnerships and making it more difficult to link into neighbourhood management structures. This had affected two sites, in particular.

Third were problems of co-terminosity. A lack of co-terminosity across PCTs and local authorities and multiple partnerships spanning different boundaries could lead to lack of capacity to engage. As demonstrated in the descriptions of case study sites (Appendix 3) five PCTs worked across a number of local authorities. This created problems in aligning priorities, providing input and manpower to local partnerships especially in areas with numerous district councils or supporting LAAs across different councils. The OSCs struggled to engage all the stakeholders across such a wide area and the VCS described difficulties in co-ordinating their work across large geographical areas. Resources to cover the costs of VCS involvement were limited and the lack of an umbrella VCS body could make it difficult to coordinate views.

Fourth were perceptions over unequal status of the VCS. In four sites interviewees from the VCS expressed the view that engagement in partnerships was tokenistic, as one interviewee commented:

'The VCS is often seen as a kind of poorer partner, you know, we need to feel privileged to be able to get at the table. Well that's not the right approach and actually it should be what we can learn from each other.' (Phase 1)

This could lead to a failure to link the work of the local VCS into wider partnership strategies and targets. However in one case study site there were joint strategies for commissioning from the VCS.

The JSNA, further described below, was seen as promoting partnership activity.

6.3 The Joint Strategic Needs Assessment

The JSNA is intended to inform commissioning strategies through an assessment of the health needs of the population across a local authority area. It provides a more systematic approach to the analysis of local data combining health, social care and other information. It also had the potential for monitoring the impact of investments over time.

Having just completed the first round of JSNAs at the time of first phase interviews, PCTs broadly viewed them as being 'work in progress'. Interviewees in a majority of sites claimed that while the issues raised in the JSNA were not new, the JSNA had informed commissioning decisions, aided targeting and locality planning, improved links between health and social care and in sharing information sometimes at locality level. In some cases, it had informed the work of joint health and social care teams, promoted a shared understanding of concepts such as needs assessment and developed joint commissioning. One interviewee commented:

'So I suppose the difference the joint strategic needs assessment has made is it is a more systematic approach to looking at data sources and making judgments, drawing hypotheses about what those data sources tell you in a way that we haven't been able to do before. So that's really helpful, and because our services are joined up, we have joint health and social care teams, that makes a lot of sense in planning terms.' (DPH, Phase 1)

In some cases, the JSNA had highlighted variations in access between localities or had helped align priorities across local organisations, such as district councils, PCTs and county councils. Some JSNAs included scenario modelling across PCTs and local authorities in relation to changing health needs. In four sites, the JSNA was locality based or was being developed in this direction. Interviewees raised a number of issues, discussed below.

6.3.1 How joint is the JSNA?

While the JSNA was generally perceived as a spur to wider partnership working, interviewees also raised questions over the extent to which JSNAs were built on joint approaches to assessing needs, to accessing and triangulating data or as a resource to underpin commissioning and priority-setting across both organisations. There was variation in the extent to which it was considered a joint document reflected, for example, in the existence of JSNA leads in the local authority, a shared evidence base aligned with key themes of the Sustainable Community Strategy or a shared definition of key concepts, such as needs assessment. It was noted by some

PCT interviewees, for example, that local authorities often considered PCTs responsible for health, and health needs assessments could therefore conjure up quite different tasks in the two organisations. In two sites, the JSNA had been led by the local authority and in one site there had been difficulties over sharing health and local authority data, which had affected the development of the LAA.

While public health teams and local authority managers from the relevant directorates were routinely involved in developing JSNAs, progress was influenced by the extent to which there was already a shared data platform. In some of the sites, shared web-based systems which made it easier to collate and present findings had been in place for up to 10 years.

6.3.2 Involvement of practice-based commissioners

*The Commissioning Framework for Health and Well Being*⁷ described the JSNA as a joint endeavour across councils, PCTs and practice-based commissioners (p.8). The national survey of PCTs showed that 37 per cent of respondents thought practice-based commissioners were involved in the JSNA, although there was no indication of the degree of involvement.

While business cases prepared by practice-based commissioners had to demonstrate relevance to the JSNA, there was little engagement of practice-based commissioners with the JSNA in our case study sites and involvement with (as opposed to knowledge of) the JSNA was evident in one site only. In another site, engagement was being developed through working with practice-based commissioners in locality-based commissioning, to be reflected in the JSNA. One interviewee commented that practice-based commissioners should 'demand more' of the JSNA process and influence its design while another noted the benefits of involving GPs with the JSNA as it helped demonstrate how their activities contributed to city-wide benefits. This reflects the often tangential relationship between PBC and PCT commissioning processes.

6.3.3 Involvement of the Voluntary and Community Sector in JSNAs

Involvement of the VCS in the JSNA appeared limited. In three sites, VCS interviewees had little knowledge of it and in five sites, while VCS interviewees were aware of the JSNA, they had little influence over its development. In one site, some VCS groups had been excluded as it was considered there were conflicts of interest as a result of their also being involved in providing services. Only one of the interviewees from LINKs had been involved (further discussed in Chapter 7). These results differed from the national survey which showed that 58 per cent of PCT respondents said the voluntary sector was involved and 43 per cent said LINKs had been involved.

6.3.4 Local variation

Despite the small number of case studies involved, different approaches to developing the JSNA were evident: one site chose to focus on areas where (1) not enough information was available; (2) there were joint concerns; and (3) action could be taken on findings. In this example, a joint approach was taken from the outset:

'So for each of those projects there's someone from the public health department, there's a local authority officer and there's a steering group above it. So every project has ...local authority/public health working together on an area of joint concern, and so there's an operational group which kind of oversees that which reports to the steering group.' (Associate DPH, Phase 2)

Another site chose to triangulate information from different sources to test assumptions, model scenarios of the impact of changes in the demographic structure and encourage discussion over the wider determinants of health across different sectors.

A third site was using forecasting software which enabled recent information to be weighted, thereby providing a more accurate picture of future trends.

One PCT had enabled joint working across the local authority and the PCT through a joint performance management tool. However, a number of concerns were raised by PCT interviewees regarding performance management across organisations, including a lack of an equivalent performance management system to WCC within the local authority and difficulties in providing joint data for performance management. The extent to which the JSNA influenced commissioning decisions and the deployment of resources was an area that required evaluation.

It was argued that the JSNA was constantly developing and should act as an evidence-based resource across the different partners reflecting ways of working, rather than a product, or 'glossy document'. For example, a core database could be made available on-line, shared and linked to more detailed health needs assessments.

6.4 Joint posts for Directors of Public Health

Most of the DsPH in the study were jointly appointed across the PCT and the local authority, but typically continued to work within, and remain accountable, to the local PCT. It has been argued⁹¹ that the creation of joint posts is an attempt to resolve tensions between the local authority role in improving the health of the population and the location of DsPH within the NHS since the 1974 reorganisation. This is both a recognition of complex governance and accountability arrangements at a local level in relation to health and well being and a response to it. However, much appears to depend on the individual qualities of those concerned.

While discussion of joint posts with local authorities was largely limited to DsPH, there were also examples of joint appointments for services for children and young people and plans for joint executive teams to facilitate joint working and oversee progress. Joint DPH appointments across PCTs

and local authorities were in place across eight out of our ten case study sites and were considered a further lever for joint working, through aligning PCT priorities and LAAs, sharing data and bridging the organisational and cultural divide. However, there were difficulties in carrying out a joint role, in influencing the local authority in relation to wider determinants of health and in aligning financial decisions across the organisations. In one site, for example, changes in the political complexion of the local authority had meant that planned joint appointments had had to be shelved.

One concern was that the health and well being agenda was dispersed across most local authority activities:

'Things that influence public health that are within the remit of the local authority are actually spread throughout the structure of the local authority, so there's no one bit of the local authority that does public health because everything from housing, transport, economic policy, parks and countryside, children and young people services, adult social services, I mean you name it, it all has an impact, one way or another, on public health. ... But because it's not brought together and focused in one place it's very difficult to get a handle on it all.' (DPH, Phase 1)

This view was reflected in comments over the way that a health and well being agenda was dispersed through the partnerships feeding into the main LSP.

Second there were problems with 'serving two masters' and one interviewee questioned whether it was possible to span both roles given the fact that governance arrangements for DsPH ran through the PCT rather than through the partnership. In particular, there was a contrast between a PCT agenda, which was largely about healthy lifestyles, and a local authority role in assessing the health impact of local policies and promoting environmental and social regeneration:

'The impression I get is that it's only the real minority of local authorities that have really embraced the idea of a jointly appointed director of public health and given that person real managerial responsibility in the local authority and the wherewithal to deliver what's required.' (DPH, Phase 1)

There were arguments for separating functions, described as follows:

'Someone who really focuses on world class commissioning, PCT agenda and kind of really focused on perhaps the integration of all the healthy lifestyle work, sort of behavioural, a bit of weight management, all that kind of stuff. And then you have someone in the local authority who actually is the one who kind of talks about the health impacts of what is going on in the local authority, and about shaping the environment and regeneration and local development frameworks and spatial policies and all those sorts of things. I don't think you can satisfactorily do the two things.' (Deputy DPH, Phase 1)

Third local authorities had a democratic mandate and a relationship with the political community that was lacking in the NHS. This led to different ways of working from PCTs. It also led to ambiguities over public health leadership across PCTs and local authorities:

'Local authorities have some form of democratic accountability but the lack of clear co-ordination ... in terms of public health leadership between local authorities and NHS organisations, and PCTs in particular, have meant it is very hard to understand where leadership on a public health agenda is, what communities or local areas are covered and

how that actually, you know, is planned, organised and how there's strategic direction.'
(National stakeholder)

One suggestion was that public health teams should be located within the local authority with accountability to the LSP.

6.5 Joint commissioning

Interviewees were positive about the potential of joint commissioning, which reduced time consuming wrangling about relative contributions to a budget and helped promote shared priorities and outcomes. Some described how the impetus for joint working in relation to health and well being had been inspired by a recognition that improvement could only be achieved through working together and that working collaboratively with social care could help shift the balance towards prevention:

'And when you look at that and the information we put in DPH Annual Reports etc it's people recognising that they didn't like the picture that was emerging ... and recognition that the only way we're going to make a difference is by working together.' (DPH, Phase 2)

There were debates over how formal the process needed to be or whether budgets could simply be aligned under a memorandum of understanding. It was argued that much could be achieved through alignment, avoiding the complex governance arrangements required in order formally to pool budgets but arrangements had to be clear. Six of the case studies had pooled budgets for health and well being services. While clear governance arrangements were needed for shared budgets, there were concerns from interviewees that such arrangements were not always in place.

'You can have all the best partnership arrangements but unless you bring the resources together under a pooled budget or a very clear aligned budget with a memorandum of understanding you inevitably, no matter how good the relationship is, there are moments of tension and difficulty, you know, when wider organisational pressures kick in.' (Director of Commissioning, Phase 2)

Interviewees highlighted a number of healthy lifestyle initiatives where organisations were working in partnership, mainly funded through growth money. Examples included the following.

- Weight management and smoking cessation services.
- Health and well being funds shared with the local authority where PCTs provided most of the funding but the local authority was the accountable body. This had the benefit of protecting resource over a longer period in order to achieve health outcomes.
- Joint posts for developing local neighbourhood approaches.
- Initiatives related to food and physical activity.
- Joint commissioning groups across the health and local authority reporting to the partnership structure.
- A public health coordinating group in a local authority, chaired by a joint DPH.
- Healthy lifestyle managers integrated with PBC consortia to encourage health and well being initiatives in PBC.
- PBC working with local authorities to develop healthy walks and employ health trainers.

- Joint working across health and social services over telecare services.
- Free swimming during the day.

It was argued that the impact of 'collective public health effort' needed to be evaluated through health impact assessments. There were areas of joint investment but these were tracked through the governance arrangements of different organisations. It was argued that an integrated governance solution across agencies needed to be developed.

6.6 The impact of the economic downturn

Second phase interviews, in particular, reflected concerns that financial stringency could promote 'cost shunting' across organisations, with each organisation focusing on its own boundaries and budgets. Others thought the opposite - that a lack of resources would make organisations keener to share functions and work together in order to make the best use of limited resources. In one of the sites, stakeholder meetings across the local health economy had been held, including the PCT, the voluntary sector, local authorities and the private sector, in order to discuss the economic downturn. The aim was to consider effects across the whole health economy and to ensure that decisions were not made in isolation. A Director of Finance commented:

'Because the danger in all of this is that if you do something in one part of the economy and it has an unintended or sometimes intended consequential effect somewhere else you just move the problem. We want to avoid that by, and I think the only way you can really do that is truly understanding what all of the partners' strategic direction and intentions are so that we aren't creating additional problems for ourselves.' (Phase 2)

In the same way, the QIPP initiative could encourage a creative approach to partnership and care pathway development across health and social services. In one site, the local authority was represented on the strategic commissioning group of the PCT and participated in joint QIPP events.

In summary, governance issues between organisations related to cultural differences between partners; the conjunction of democratic accountability with other governance arrangements; the impact of an active relationship with the political community in local authorities; ambiguity in carrying out joint DPH roles; and difficulties in targeting effort given the breadth of the agenda. Successful partnerships could be gauged by the extent to which public health had been mainstreamed within the wider partnership and subsequently reflected within LAAs and the extent to which partners were held to account through the mechanism of the LSP. Governance failures could be represented through continued 'silo working' in public health and the lack of integrated multi-agency structures.

The following chapter outlines issues raised by interviewees in relation to the principle of accountability to the public.

7 Public involvement in commissioning

Accountability to the public is a key aspect of governance and this chapter is concerned with public involvement in commissioning decisions and in local scrutiny. It begins by outlining the policy context (7.1) then discusses the range of initiatives for involvement in PCT commissioning and barriers to greater involvement (7.2). It reviews accounts of public involvement in PBC (7.3) and discusses the developing role of LINKs (7.4). Views of VCS members of health and well being sub-groups of LSPs on their role in decision-making are reviewed (7.5) followed by a discussion of public involvement in the scrutiny function (7.6). While there is a spectrum of engagement from involvement in decision-making at one end to receiving information at the other, the study demonstrated that more effective involvement was needed and illustrated a number of barriers to achieving this, especially in relation to the preventive agenda.

7.1 Policy context

As discussed in Chapter 3, policy and commissioning guidance emphasises the role of patient and public involvement in commissioning decisions. It is intended that involvement should mirror the commissioning cycle from assessment of health needs to strategies for prioritising investment (or disinvestment).⁵¹ In addition to one-off events, this may be achieved through formal membership or involvement of the VCS or LINKs in decision-making bodies such as LSPs and their various sub-groups, in PBC consortia; or through PCT Boards and committees. OSCs are also a key route for ensuring public accountability, given their role in promoting the well being of local communities through 'effective scrutiny of health care planning and delivery and wider public health issues'.⁹² PCT interviewees described a wide range of schemes, further described below.

7.2 Involvement in PCT commissioning

PCT interviewees described a range of initiatives for involving the public in decision-making, although interviewees in half the sites considered that more needed to be done. Initiatives included the following:

- large stakeholder events to inform strategy
- focus groups and patient panels
- 'health' conversations
- telephone surveys
- a public strategic commissioning forum
- the payment of sessional fees to members of the public

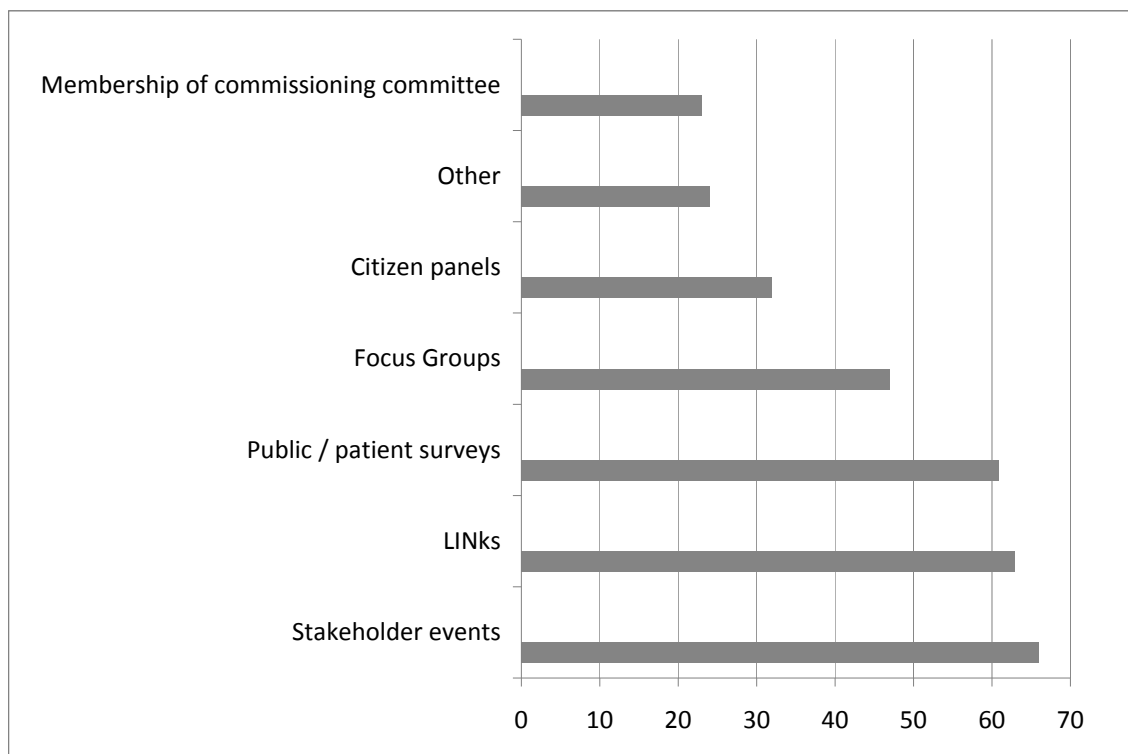
- developing networks for patients to become involved in service redesign, pathway work and service specification
- population profiling and social marketing to identify better ways of
- engaging with specific populations and also to encourage greater involvement
- lay representatives on sub-committees of the PCT Board
- public consultation events prior to PCT Board meetings
- meeting in different locations
- engaging with patients already in the health care system
- joint strategies with local authorities, including locality forums
- working through local VCS organisations
- representative patient advisory forums.

The national survey indicated most commonly used routes. We asked respondents the following question: can you describe what mechanisms exist in your PCT for involving local people/groups in decision-making relating to commissioning for health and well being? We received responses from 70 PCTs. Respondents were told they could select as many choices as applicable to their PCT. The results are illustrated in Figure 2, with the number of PCTs using these methods appearing on the x axis.

The survey also requested examples of where local people or groups had influenced commissioning for health and well being services. There were more than 70 responses to this question with most falling into the following categories in order of popularity: consultation as part of JSNA process (focus groups and surveys); consultation as part of formulating commissioning strategy plans (e.g. 'visioning events'); input into service (re)design (e.g. sexual health, mental health); consultation as part of prioritisation processes and focus groups used in developing social marketing.

There was variation in the extent of public involvement. In one site there was direct involvement in commissioning through participation in assessing bids but, in general, public involvement was considered difficult to achieve and PCT interviewees identified a number of barriers to effective engagement. First was the difficulty of representation and the importance of avoiding over-representation of 'single issue' factions. For example, in two of the sites, engaging with rural populations created difficulties. One interviewee also argued that the definition of "hard to reach" should not become stereotyped: commissioning strategies should also include commuters living in dormitory flats.

Figure 2. Ways of involving local people



Second PCT interviewees from eight sites commented on the relative lack of interest in population health from the public which meant that public interest and involvement was skewed towards health care services.

'I keep saying this to loads of people very boringly that most people, you know, if they're not ill, are not really focused on health. What they're focused on is have they got enough money to live, you know, is their house in good condition, you know, is there poverty around and all sorts of other things that absolutely are determinants of ill health, but they're the most important things in people's heads.' (Deputy CE, Phase 1)

Public health lacked visibility, received less public and media attention, was interconnected with broader social issues and was described as low on the public's 'worry list'. There was little demand for preventive services.

'It's not unique to the UK, most countries have this problem, and that's because the public can see health care. They can see health care, for some reason, but they can't see health; health is pretty much invisible.' (NED, Phase 1)

A further barrier was a lack of natural points of contact for engaging the public with the health and well being agenda, as opposed to a health care agenda. The same interviewee commented:

'The problem we've got with public involvement, as a concept, is that we tend to involve people who are or have been ill to get into these decisions because their experience of the service allows them to bring a perception or a perspective to the purchasing of future services. Of course what we're trying to do here is to involve the people who've never been ill ... and so involving the public in public health is quite a difficult thing to do.' (NED, Phase 1)

Despite policy priorities for a stronger voice for local communities in commissioning, focus group participants and VCS interviewees indicated

that, in practice, local engagement in decision-making was minimal and there was little local accountability. While the process for prioritising was likely to become more transparent as patients and the public became involved, tensions would remain between achieving economies of scale offered by large commissioning organisations while at the same time encouraging local involvement.

7.3 Involvement in practice-based commissioning

In most sites, public involvement in PBC was described as 'developing'. Examples included: the public being invited to attend consultations on PBC plans; PBC developing links with local groups around specific conditions; public representation on a local PBC board; public involvement included as part of Local Enhanced Services; and public involvement in pathway redesign. In two sites, however, PBC consortia had wide membership including social services and representatives of the public and in one of these sites there was public involvement not only at practice level but also within locally-based partnerships. In two sites, public involvement at PBC level was poorly developed, with a PBC lead commenting:

'The other gap I think in terms of practice-based commissioning is that there isn't much direct patient or public involvement in it either, so perhaps we're not seeing things from that perspective as much as we could do.' (Phase 1)

Even where there was apparent involvement, a PBC lead stated that public views were insufficiently represented:

'I mean every practice has a public involvement group, and the practices are represented by the elected members, and the elected members sit on the executive. You know, from that point of view you could say we are represented But it's, again a lot of the meetings we talk in medical jargon, and it's quite strange for somebody sitting in on a meeting.' (Phase 1)

With the exception of one site, PBC interviewees had not heard of LINKs, and a few were sceptical about the benefits of public involvement in decision-making:

'I think you can go too far because at the end of the day we're the experts. What we have to do is look at what's going on around, apply our experience and knowledge to it, knock it into shape, and then try and get it in a form that we can share with the public so that they can see what we're doing.' (PBC lead, Phase 2)

However, as discussed below, representatives from the VCS and LINKs felt they could play an important role in influencing commissioning strategies. This would improve accountability to the public, as they could both gather and disseminate relevant information through their members and through local networks. The following section begins by discussing in more detail the influence of LINKs in the case study sites before discussing the role of the VCS in LSPs.

7.4 Accountability through Local Involvement Networks

LINKs are accountable to the public through publishing an annual report of activities and report directly to the Secretary of State for Health. Operating

independently from the local authority, they have their own governance structures and decision-making processes.

LINKs were in place in seven of the case study sites in first phase interviews, although five of these were still working through interim arrangements (see Appendix 3). There was usually an overarching board, which included individuals and representatives from organisations. Where permanent arrangements for the LINK were in place, the board had been elected and governance arrangements and a code of conduct agreed.

At the time of the interviews, none of the case study LINKs had developed a work programme for health and well being. They saw their role as developing networks and engaging at grass roots level, taking the views of local people to commissioners and *vice versa*. In addition, LINK interviewees saw their role as constructive partners, challenging commissioners to achieve the best possible services for local populations, and as educators, encouraging local populations to understand and engage in decision-making. They could also act as a counterbalance to a medical model of health and well being. LINKs offered an opportunity for wider networks to be developed, including health and social care and the VCS. In one site, for example, the LINK was developing a stakeholder group with representation from the PCT, local authority and additional partners.

LINKs engaged with the public in various ways, including stakeholder events, open board meetings and communication through the local VCS. Information was disseminated through websites, leaflets, minutes from meetings and an annual report. The partnership and membership within LINKs, particularly of the VCS, was seen as a useful way to cascade and disseminate information to a variety of organisations. However, LINKs faced a number of challenges common to public involvement strategies, in particular, achieving representative membership:

'But I do think that LINKs has got to make sure that it doesn't become ... the 'usual suspects' syndrome where you just turn out the same people all the time. There's nothing that makes you less credible than that, and LINKs has got to make sure that doesn't happen.' (LINK Chair, Phase 1)

Moreover, two LINK interviewees raised issues of insufficient financial resource or time to fulfil duties; lack of support from the hosts; concerns that LINKs was just reinventing the wheel and the lack of a government campaign to publicise their existence. It was more difficult to engage with social care than with health and LSPs could prove difficult to 'break in to'.

Most interviewees felt that it was too early to influence PCT decision-making as they were still forming relationships. Most had little or no input into targets or priority-setting although there was some 'informal acknowledgement' by PCTs of their views. Some considered that LINKs had achieved less engagement than the PPIFs which preceded them, although it was difficult to measure public engagement in commissioning or assess influence:

'I think it's a difficult thing to do because there are various strands to it and not all easily understandable and you can be involved in something like being consulted on some service or

some change in service without realising that you're actually being involved in commissioning, and I think there's quite a lot of that going on.' (LINK Chair, Phase 1)

PCTs were often perceived as commissioning according to a preconceived agenda and it was argued that greater clarity was needed over the role of LINKs within statutory organisations:

'It still sort of feels as though it's very much like yes we're really interested in what you think about what we're doing, rather than 'what should we be doing'.' (LINK Chair, Phase 1)

Given the early stage of LINKs in first phase interviews, second phase interviews included three interviews with LINK Chairs. In two sites, there seemed little interest or engagement from the public and one interviewee commented that the public was only interested when they wanted to use the service: that there was a need 'to awaken public interest in their own responsibility in this regard'. This meant that recruitment to LINK management boards had proved difficult and raised questions about their sustainability. There had been little engagement to date with formal decision-making structures of the PCT, with PBC, with the LSP, the JSNA or with local voluntary organisations.

In one site, however, there was one very active LINK that had exerted an impact on PCT specifications and contracts. It held a non-voting seat on the PCT board and was represented on the provider arm of the PCT, various task groups and committees and the local health and well being committee. There was extensive membership with around 600 members and 200 organisations, described as follows:

'So, for example, LINK works on the premise that anybody can be a member of LINK, whatever member means, and our job is to make sure that we are continually giving them information about what's happening in the health and social care world ... it's no good a group of clinicians and administrators sitting in the PCT working out what specification it ought to be, because they get some disasters. They've got to be out there in the community and in my opinion they have to use LINK to do it.' (LINK Chair, Phase 2)

In this case, a clear distinction was made between the PPI forum, the voice of the patient, and the LINK, the 'facilitator of the voice' with its connection to the community.

Although, as reflected in guidance, LINKs were linked with OSCs, they were yet to form strong relationships with partnership organisations, such as LSPs, or with practice-based commissioners, many of whom seemed unaware of LINKs at the time of the interviews. Where relationships with LSPs were present, these were often as a result of pre-existing contacts. It was argued that the structure of local partnerships and LINKs's place within them needed to be clarified, and that there should also be clear routes through which LINKs could influence social care.

The majority of PCT interviewees acknowledged LINKs' potential value as a source of information and a gateway to systematic engagement with the VCS. In one site, the LINK was integrated into the JSNA process as well as into commissioning sub-committees of the PCT Board, and in two sites LINKs had a seat on the PCT Board. However, many PCT interviewees were unclear to what extent patient representatives might also be members of

LINKs, which were generally viewed as forming only a part of wider engagement strategies. One interviewee considered that they reflected a 'diffuse series of constituencies', and were not a suitable proxy for patient and public engagement. The latter was of a higher priority than involving LINKs *per se*:

'It doesn't matter to me, do you know what I mean? As long as I've got members of the public engaged in it, in terms of looking at what we're going to do.' (Director of Quality, Phase 2)

In both phases of interviews, relationships between LINKs and umbrella bodies for local voluntary organisations could be a source of tension, due to overlapping networks and some duplication. The study demonstrated wide variation in the development of LINKs and as well as in engagement with them and this variation was more marked than for any other aspect of the study.

7.5 Accountability through partnerships

VCS members of health and well being sub-groups of the LSP commented on ways of improving public involvement and the VCS role in influencing priorities through the LSP. These are described in turn.

7.5.1 Developing public involvement

VCS interviewees made a number of suggestions for improving public involvement in decision-making. It was important to engage with the public over issues of local concern or changes in services but there was inadequate feedback to the public over how decisions were made, a view that was also shared by PCT interviewees from two sites. Two VCS interviewees stated public involvement and engagement with the VCS had been a largely 'tick box' exercise:

'It doesn't really happen, well not in commissioning. I mean everybody talks about commissioning. I think it's very hard to see the direct relationship between local people's input and how that's actually influenced the commissioning decisions.' (VCS member, Phase 1)

The impact of involvement should be made clear with better channels of communication between commissioners and the public:

'I mean I think people are more likely to become involved in activities if they think they're making a difference, and I think what has happened in some cases in the past has been where people have come along to consultation events, they've given their views, they've taken the time to do that, and they never know what has happened to them, or they think perhaps they've been ignored.' (VCS member, Phase 1)

Two VCS interviewees felt PCTs sought public views after a decision had been made. Public involvement needed to be improved across the commissioning cycle and in investment scenarios. Links with PBC were poorly developed and the VCS role within formal partnerships could be strengthened. However, structures for involving the public in decision-making were complex and the use of NHS jargon could prove a barrier.

7.5.2 Accountability through the Voluntary and Community Sector

In three sites, VCS members of partnerships saw their accountability to the public as achieved through their networks. Also as one interviewee commented, the VCS were accountable through their membership and governance structure:

'I think one of the things that the voluntary sector has got by dint of its structure ... every charity has a governing body, a board, which is made up of voluntary trustees, that's why it's the voluntary sector, so you've got people who are drawn from local communities who are, if you like, in charge of these organisations and if boards are functioning properly that's where a great deal of your public accountability comes from.' (VCS, Phase 1)

However there were difficulties in influencing partnerships and a number of difficulties were voiced by VCS members of health and well being partnerships of the LSP. It was considered by one interviewee that not bringing money to partnerships meant that the VCS was considered an inferior partner. Decision-making was described as taking place in the main LSP and while the VCS was involved in the delivery of priorities, there was less influence on setting targets and agreeing priorities. This was particularly the case for two tier authorities. Engagement was often tokenistic but in two sites VCS interviewees described themselves as playing a role in choosing LAA priorities and, in one of them, a third sector assembly had been established around LAA themes.

The potential synergy between partnership strategies and the work of the VCS was not adequately exploited as partnerships were often unaware of activities carried out in the sector. This could lead to duplication, opportunities to build on existing plans could be missed and commissioning decisions were not informed by intelligence from the VCS.

'I think most of the time they (VCS) spend just reacting and doing rather than thinking proactively about how they could get involved more in the strategic areas and how they fit with certain policies and strategic direction. ...They don't see how they fit with some of the targets, they don't see that they fit with the local area agreement and that some of the work that they're doing contributes to that.' (VCS member, Phase 1)

Involving the VCS had been made more complex due to competitive tendering and changes in procurement guidance. The combination of commissioning and provider roles could also create conflicts of interest. It was argued that one of the drawbacks of WCC was that it was geared to major providers and this made it difficult to contract with the VCS even though they were in touch with those least likely to engage with services. A number of interviewees commented on the need to take a more radical approach to commissioning preventive services, drawing on new ways of working from the VCS. One interviewee commented:

'Instead they're giving the contracts to the big nationals and those nationals haven't got the local social capital, the local sign-up, the localism.' (VCS member, Phase 1)

Interviewees described ways of improving partnership working at a local level although much depended on the local context. Locality networks of various kinds could span health and social care and the wider health agenda, and community assemblies could provide a focus for community

views. Practice-based commissioners could also become involved on a locality basis.

7.6 Public involvement in health scrutiny

Chairs of health scrutiny committees are publicly accountable through being elected as councillors. OSC interviewees concurred with VCS interviewees that public involvement in PCT decision-making required development. However Chairs of health scrutiny committees described public involvement in the scrutiny function as minimal. One interviewee commented:

‘Pretty poor, I’d say, because basically I would say most of the public would be completely unaware of the work of the scrutiny side of things. I think in my time I’ve chaired health for a year and a half, and we’ve had one deputation, which bearing in mind that would be the only way of the public getting involved is pretty low.’ (OSC Chair, Phase 1)

Sites differed in the extent to which members of scrutiny committees sought out views of the public and in two sites there was a more proactive approach to public engagement. One interviewee described how they were improving engagement:

‘So it’s taking scrutiny into the community where it should be, not just tied up as we’re sitting up in ivory towers so to speak and sending loads of literature out to people, a waste of time. You meet people face to face’ (OSC Chair, Phase 1)

As part of this, it was argued the public needed to be more aware of how they could influence decision-making in the health care system. On the other hand, commissioners needed a better understanding of levers to promote communication and engagement with the populations that they served. A number of different routes were discussed including Mosaic profiling, working through umbrella VCS organisations or LINKs, independent social marketing initiatives and raising the profile of the PCT through sponsorship. Other examples included face to face canvassing to increase public awareness of the health agenda and marketing routes through which the public could potentially influence commissioning decisions.

In common with LSP sub-groups, scrutiny committees were themed and each had a discrete remit, making it difficult to make links across a wider health and well being agenda. There were a few examples of scrutiny of health and well being strategies, health inequalities and the LAAs, but, in general, there was little scrutiny of partnerships, of LAAs, of preventive services or of health protection. Instead the focus was largely on scrutiny of PCT targets and priorities, often in response to public concern. OSCs did not figure prominently in PCT accounts of governance and some argued that they did not present enough of a challenge to PCTs.

As mentioned at the beginning of this section, the lack of visibility of public health means that reflecting concerns of the public by scrutiny committees may not lead to the scrutiny of services for public health and well being, despite the role envisaged for OSCs in this regard. Focus groups commented that OSCs were typically focused on the health care system and did not reflect the wider public health system.

From a governance perspective a number of themes emerge from this chapter. First is a lack of clarity over the degree of influence to be exercised in statutory organisations, reflected in the varied involvement of LINKs in PCT Boards and sub-committees. Second there are differences in how public involvement is interpreted. It was clear from interviewees in four PCTs (and the corresponding LINKs interviews) that, while the PCT was trying to involve the public in commissioning for health and well being, there was little evidence of the public influencing commissioning decisions. PCT interviewees saw public involvement in commissioning as reflected through informal engagement with the public while VCS interviewees expected more influence and direct formal involvement in decision-making, a view expressed by one interviewee as follows:

'But when you ask public to be involved, engaged, their hopes are high, and they think they're going to alter or are able to alter the decision, whereas for the commissioners engagement means something else.' (VCS member, Phase 1)

Paradoxically, increased public involvement may lead to less emphasis on a public health agenda. The economics report carried out as part of the project noted the relevance of one of the theorems of public choice theory, the Median Voter model. This suggests that the rate of output of public goods is determined by the median voter, because the government maximises its chances of re-election by reflecting the median voter preferences (or, more accurately, the government's perceptions of these).⁹³ Focusing on median voter preferences may neglect the needs of minority groups and those with the poorest levels of health and well being and so exacerbate existing inequalities. Moreover, longer term needs for investing in health and well being may not be appropriately valued by the median voter because of uncertainty about longer term benefits. This has direct relevance for commissioners who act as 'agents' representing the principal (the public). They need to ensure that their role as 'agent' on behalf of principals fairly reflects the needs of the most deprived groups and that robust, longer term evidence informs commissioning decisions. If commissioners invest for the longer term the opportunity cost of that investment may be the more urgent and immediate demand for funds from the acute sector. This issue is further discussed in Chapter 9.

8 Economic perspectives on incentives and contractual flexibilities

While governance structures described in Chapters 5 and 6 can also act as incentives and shape performance, this chapter focuses on incentive arrangements and contractual flexibilities available to commissioners, with particular emphasis on their applicability and deployment to health and well being. Data from the national survey and from both phases of fieldwork are analysed in the context of economic perspectives on incentives. A more detailed analysis is provided in a review of the economic literature on incentives for commissioners (working paper 3).

Commissioners can draw on a range of incentives to encourage the provision of additional services or improved performance to meet specific targets. Incentives may also be included in contracts for providers, whether located in the NHS, the private sector or the VCS. They may also be targeted at consumers to incentivise changes in lifestyle or to encourage access to services.⁹⁴ With the separation of commissioning from provision there is a requirement to specify contracts (and the option of including performance incentives) and promote competition through the tendering process. *High Quality Care for All*¹⁹ suggested incentivising quality improvement through 'Commissioning for Quality and Improvement' (CQUIN); prevention through improvements to the GP pay-for-performance system, the QOF; and integrated care through support for practice-based commissioning and the introduction of integrated care pilots. Other incentives available to commissioners included the optional Local Enhanced Services (LES) element of the GP contract, reward schemes for practice-based commissioners or extensions to nationally agreed contracts, such as 'QOF plus' schemes. Financial incentives are also linked to the reward element of LAAs, which are shared among partners. This chapter considers options available to commissioners and explores the extent to which LESSs, reward schemes and contractual flexibilities are effectively deployed for promoting health and well being.

8.1 Theoretical background

While ideas of agency, motivation and incentives are often considered central to improved performance, there is a 'lack of coherent established theory with predictive validity' on the use of incentives in health care and 'we are still a long-way distant from any comprehensive theoretical and empirical accounts'.⁹⁵ Notwithstanding these limitations, this section considers a selection of theoretical economic approaches and explores their implications for commissioning health and well being services. It builds on a previous review by Davies et al.²⁶ who used a Governance-Incentives-Outcomes (GIO) model to analyse incentives and outcomes associated with three different forms of governance: markets, hierarchies and networks. The NHS in England can be characterised as a 'quasi-market', because it is

a public sector organisation which incorporates market features. The WCC framework, for example, explicitly requires commissioners to 'effectively stimulate the market to meet demand' and secure required clinical and health and well being outcomes. The co-existence of market, network and hierarchical modes of governance within the NHS gives rise to tensions, including that between cooperation and competition, integration of services and development of a competitive market and complex governance arrangements with practice-based commissioners, who both commission and provide primary care services. A market mode of governance also has limited applicability to partnership working and collaborative commissioning which are increasingly seen as a route to limiting both 'risk shunting' across commissioners and providers and 'cost shunting' across different parts of the local health system. The health and well being agenda also reflects the importance of considering 'whole system' impacts of incentives and these aspects are discussed following a discussion of economic models for understanding incentives.

Davies et al.²⁶ identified four theoretical economic models of relevance for understanding how incentives work.

- (1) Neoclassical economics, the foundation of most economic theory, explains why markets may fail and provides a rationale for government intervention in the form of national targets, regulation and taxes. It also explains why principal-agent relationships arise, for example where demand for services is expressed by commissioners on behalf of their populations: if left solely to individuals, demand for and provision of public health services would be suboptimal. Health care clearly does not fulfil the conditions for market equilibrium: there are monopolistic organisations; one person's consumption may not preclude (dis)benefits for others (externalities); patients (principals) may delegate decisions to doctors (agents) in relationships based on trust; and there is unequal access to and use of information, potentially resulting in doctors acting as imperfect agents. Other developments of the neoclassical framework include economic evaluation (such as cost-effectiveness analysis, further discussed in Chapter 9) and the 'characteristics approach', which can usefully inform local consultation to determine priorities and service design.
- (2) Game theory modifies some of the assumptions of neoclassical theory, addresses the problems of strategic behaviour and can shed light on reasons why commissioners face problems identifying suitable providers and managing their behaviour. It deals with concepts of uncertainty, risk, and the principal-agent relationship and explores how strategic behaviour affects resource allocations. It concerns the outcomes (expected utility) of rational individual decisions taken under uncertainty which gives rise to risk and subsequent 'gaming' by individuals as they interact during the decision-making process and can result in 'opportunism', that is, efforts to realise individual gains through a lack of honesty in transactions.⁹⁶ In a world with uncertainty, there are informational differences between agents: employers may not know how much effort employees are making, particularly where outputs are difficult

to measure – this is often the case in promoting health and in providing health care. These difficulties explain why commissioners use incentives, contracts and performance indicators to manage providers, but the unintended consequences of these approaches should also be considered. While neoclassical theory assumes that people will only do what they perceive to be in their own interests game theory recognises that individuals are likely to be a combination of ‘knights and knaves’⁹⁷ and may also value non-pecuniary gains such as fair treatment of themselves and others.⁹⁶ Davies and colleagues²⁶ note that game theory is being developed to tackle some of the complexities of decision-making in the public sector, and it appears that an understanding of the principal-agent problem is increasingly informing the design of performance management within the NHS.

- (3) Institutional economics and experimental economics can help to shed light on potential solutions to the problems identified by game theory. Institutional economics is of particular relevance to commissioners as it provides a ‘science of contracts’ which gives insights into contracts and incentives and can either be incorporated into contracts, or used separately.⁹⁸ Contracts are a way of mediating the relationship between commissioners (principals) and providers (agents). Institutional economics also sheds light on contractual relationships, defining the associated costs as ‘transactions costs’.⁹⁹ Theories are based on an analysis of principal-agent relationships in centralised (hierarchical arrangements) and devolved systems (market-type arrangements). This is further described in section 8.2.
- (4) Experimental economics suggest that individual-level incentives can be effective in changing behaviour, but that it is important to work with ‘human frailty’ rather than trying to override it. It explores how ‘extrinsic’ motivations provided by those attempting to manage performance can affect ‘intrinsic’ motivations of those being managed.¹⁰⁰ It has potential to address the ‘crowding out problem’, in which the use of targets or financial incentives damages altruism or intrinsic motivation.²⁶ Davies et al.²⁶ cite theoretical analyses which suggest that low-powered incentives, and low levels of monitoring, allow principals to communicate their trust and value to agents. This branch of economics is particularly useful when changes in individual behaviour are sought, but commissioners should also be aware of these factors as they can help differentiate the potential effectiveness of alternative provider schemes. ‘Nudge economics’ offers approaches to promote and encourage behaviour that improves health and well being, whilst supporting free choice. This is discussed further in relation to incentives for behaviour change.

8.2 Institutional economics and incentive contracts

This section considers how commissioners can use contracts and incentives. Incentive contracts are one way of ensuring that the agent bears some of the risk or responsibility for the outcomes of their actions. There are several principles governing the design of optimal incentive contracts ¹⁰¹ (pp. 240-241) and Table 6 summarises these principles and their implications for

commissioners' use of incentives drawing on Milgrom and Roberts¹⁰¹ and Williamson.⁹⁶ Activity-based funding as a means of incentivising improved health outcomes and the efficiency and quality of care is also considered.

Table 6. Economic principles for optimal incentive contracts

Principle	Definition	Implications for commissioners
The informativeness principle	Factor in performance measures that allow agent effort to be estimated more precisely and exclude measures that chiefly reflect factors outside of the agent's control.	Commissioners may require agents to report activity data, e.g. on efforts to follow up non-attenders at weight loss clinics.
The incentive-intensity principle	The strength of incentives should reflect the marginal returns to task, the accuracy with which performance is measured, the responsiveness of the agent's efforts to incentives, and the agent's risk tolerance.	Sometimes, the most difficult to reach populations are those with greatest capacity to benefit. Additional payments could be made for reaching these populations.
The monitoring intensity principle	Monitoring is a costly activity. More resources should be spent monitoring when it is desirable to give strong incentives, e.g. substantial variation in performance or poor performance.	If benchmarking data suggest that a PCT is performing significantly below national average standards provider performance may be monitored more intensively.
The equal compensation principle	If principals cannot monitor an agent's allocation of time, incentives should ensure that the marginal returns earned by the agent are equal for all tasks the agent undertakes. Providing strong incentives for only some activities can cause agents to reduce effort elsewhere.	If local public health indicators are added to the QOF, care should be taken to ensure that targets are aligned with commissioner aims, e.g. thresholds for triggering maximum payments could be raised if unmet need is concentrated in lower income groups.

Bounded rationality, the limited capacity to process information, means that it can be difficult to agree contract terms. As real contracts are not perfect, they must allow parties to adapt but this opens the door for opportunistic behaviour.¹⁰¹ In response, relational contracts may be written that 'frame the relationship', outline objectives and procedures for governing decision-making rather than agreeing detailed plans of action. These can be enforced by a reputation mechanism.

Within this framework, this section considers the use of incentives in commissioning for health and well being through QOF, and LESs, drawing on interview and survey analysis. LESs were the most frequently cited incentive both in the survey and by interviewees and are discussed in some detail.

8.2.1 Incentives through national contracts: the Quality and Outcomes Framework

The voluntary pay-for-performance (P4P) part of the GP contract, the Quality and Outcomes Framework (QOF), designed to reward quality in primary care, includes several preventative indicators. Most of these address secondary prevention, but the 2009/10 QOF includes two primary prevention indicators for cardiovascular disease and two smoking cessation indicators.¹⁰² There are also indicators for cervical screening and vaccinations.

Although regularly updated, the QOF has been criticised for its lack of capacity to incentivise a population-based approach to health and well being. There is little incentive to proactively identify populations at risk who are not currently on disease registers, a task which is key to targeting populations most at risk of premature mortality. Furthermore, what is not incentivised may be marginalised or neglected.¹⁰³ The QOF focuses on 'activity' and provides little information on outcomes a point recently reiterated in the report of the House of Commons Health Committee on health inequalities¹² (p.9) in the context of the importance of measuring the number of successful quitters rather than the numbers given advice. There is a lack of baseline measurement for the framework and it is therefore impossible to know if real changes are being measured or current practice is simply being described.¹¹ The QOF currently offers little financial reward for additional health improvement services and has been described as a crude measure of patient management with emphasis placed on computerised data recording instead of tailored advice and support for individuals.¹⁰⁴ However, research has also shown some benefits of incentives built into the QOF. Millett et al.¹⁰⁵ concluded that financial incentives introduced in UK primary care appear to have increased cessation advice given by primary care staff and reduced the percentage of people with diabetes who smoke, with improvements generally greatest in the groups with the poorest performance before these incentives were introduced.

While evaluations of the QOF suggest that it has the potential to narrow health inequalities,¹⁰⁶ rates of exception reporting – where patients can be excluded from the calculation of performance – need to be taken into account when determining the actual impact.¹⁰⁷ However, as maximum payments are made when 90 per cent of eligible patients are 'treated', there is little financial incentive for GPs to offer services to hardest-to-reach patients who arguably have the greatest capacity to benefit. An illustration of 'the equal compensation principle' is found in recent research evaluating the impact of the QOF in primary care on targeted and untargeted clinical practice.¹⁰⁸ Delivery of services rewarded with performance payments

improved while untargeted services declined. Taking a different approach, Bernstein et al.⁸⁸ argued that reductions in NHS spending due to GPs 'assertively' addressing lifestyle risk factors such as smoking, obesity and alcohol consumption should be passed on in the form of larger PBC budgets, which would act as an incentive to improve preventive care.

A systematic review of pay-for-performance schemes, many of which covered preventative services, found mixed evidence that schemes improved quality of care. The review highlighted shortcomings in the current evidence base, which was unable to address key questions such as the optimal duration for payments or whether effects endured after rewards were removed.¹⁰⁹ A more recent study of P4P schemes in Massachusetts, US, which also covered preventative services such as well-child-adolescent visits, found no evidence of positive effects on the quality of care.¹¹⁰

Amongst some interviewees there was frustration over the inflexibility and limited opportunities for performance managing national GMS contracts, despite initiatives such as balanced scorecards or monitoring QOF points:

'The general medical contract for GPs needs to be taken apart root and branch and put back together again on evidence and policy based medicine. That won't happen because there are too many vested interests But if it did happen, you could theoretically transform the landscape by making it much more cost-efficient and much more effective in terms of curative services, rehabilitative services and preventative services.' (DPH, Phase 2)

Some considered that QOF had encouraged proactive case finding but most interviewees considered that, as currently configured, it did not adequately incentivise a proactive and population-based approach to health and well being services but had incentivised the management of long-term conditions. It was also more likely to act as an incentive for smaller and non-prescribing practices or those without large numbers of LESs. If the QOF was to support improved health and well being, new QOF points were needed:

'I think the government needs to put its money where its mouth is and it needs to change some of the QOF points to say we want a really assertive approach to obesity, we want a really assertive approach ... to smoking, to drinking, to drug taking, to exercise.' (PCT Chair, Phase 2)

In first phase interviews, two PCTs planned to develop 'QOF Plus' schemes to build in extra health and well being indicators and provide additional rewards to high performing practices, whilst offering incentives to the poorer performing practices to improve. In the national survey, we asked PCTs whether they had plans to extend QOF to incentivise health and well being. Thirty eight PCTs reported they had no plans whilst 16 PCTs did have plans. In terms of how this group described how QOF would be extended, the following areas were cited: smoking cessation; cardiovascular disease; obesity; and diabetes.

8.2.2 Local Enhanced Services

LESs are optional, locally determined service agreements with independent contractors, usually agreed on an annual basis. There is no clear definition,

but since their introduction in 2004 as part of the new GMS contract, they have provided an attractive and flexible route through which PCTs can harness a quick response from general practice in addressing local needs or specific targets for delivery. Spending on LESs has doubled since 2006, and in 2008/9, around £323 million was spent on LESs in England,¹¹¹ excluding APMS and PCTMS enhanced services.

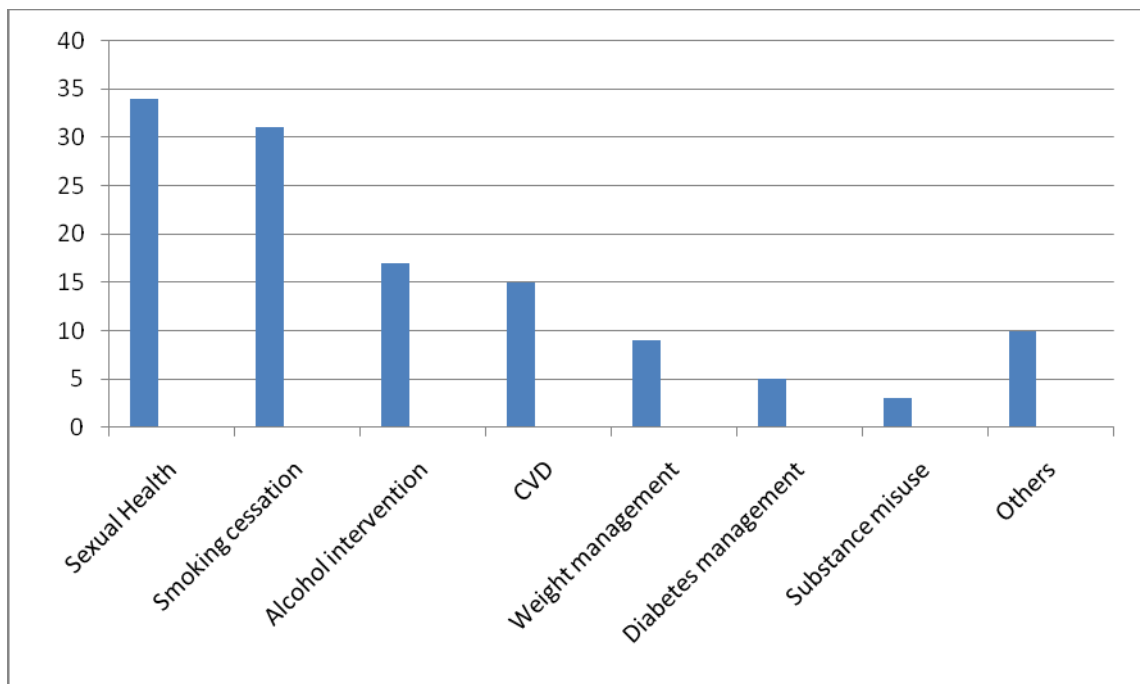
LESs were the most widely commented on financial incentive scheme by first phase PCT and PBC interviewees (33/45 and 8/8 respectively) and interviewees from all sites agreed that they were successful in motivating GPs. They were useful for meeting national or local targets, for example, in relation to smoking and obesity, but they were also seen by PCT interviewees as a way of filling gaps in the QOF, such as proactive approaches to identifying populations at risk. Some PCTs chose to weight LESs to encourage targeting of specific populations or areas (in line with the 'incentive intensity' principle in Table 6). At least two PCTs had incorporated a public involvement element into their practice-based commissioning LES and one wished to develop a LES to support healthy behaviour change through motivational interviewing. LESs fit neatly into a 'small business' model of primary care. However, they have been developed in an incremental and piecemeal fashion with some PCTs agreeing large numbers of LESs, not always aligned with their strategic plan.

As part of the study we gathered (through FOI requests) all LESs in the ten case study sites during the first phase. There was variability in the numbers and content of the LESs. Numbers ranged from ten to 26: areas commonly included were contraception, Chlamydia screening, immunisation and vaccination, tests provided closer to home and extended hours. More rarely included were agreements with practices to provide patient data on areas such as smoking, obesity, breastfeeding; information on ethnicity and first language; or initiatives related to falls prevention, proactive care of the elderly or substance abuse. Five sites had specific smoking cessation LESs with practices or community pharmacies. Many LESs related to payment for extensions to core clinical services such as immunisation and vaccination.

The national survey showed that LESs were the most commonly cited vehicle for incentivising activities to reach local targets. The survey also asked whether the PCTs used LESs to incentivise health and well being interventions. Around 70 per cent of PCTs used LESs for this purpose. We asked respondents to give examples of how LESs were used (see Figure 3). The y axis denotes the number of PCTs that informed us they were using LESs for the most mentioned conditions.

We followed this up by asking if respondents thought LESs were an effective way of commissioning health and well being services. Eight per cent of respondents rate LESs as 'very effective', 65 per cent 'quite effective', 23 per cent 'not very effective' and three per cent 'very ineffective'.

Figure 3. Local enhanced services



Arguably, LESs reflect both the advantages and disadvantages of incentive arrangements, although much depends on getting the level of incentive right. There was evidence of their success, for example, practices taking on care for a nursing home, doing 'ward rounds' which had dramatically reduced emergency admissions. Smoking cessation targets in one site had been exceeded by creating a LES for general practice that funded a more comprehensive approach to smoking cessation - with dramatic results:

'So if the practice now sees a person for the full sort of four to six weeks, they've got the person who's quit smoking and had that confirmed by carbon monoxide testing. Whereas in the past they might have got a fiver for it, they can now get up to hundred and twenty quid for that. All of a sudden, we've gone from missing the target, missing the target, missing target, to so overachieving it, it's amazing. And, you know, these are genuine quitters.' (DS, Phase 2)

Despite these advantages there were also criticisms levelled at LESs. They could increase inequalities if targeted practices did not choose to take them up and if practices did not need additional income they would not take advantage of them. Some practices were accused of 'cherry picking' LESs which led interviewees to consider that instead of there being individual LESs, they should form part of a wider package across practices. The view was expressed that providers assumed they would always be available but this was unlikely to be the case, particularly in an economic downturn. LESs did not reflect a strategic approach, were not always outcome based, there was not always adequate evidence of benefits to population health and they tended to be poorly performance managed, with weak contract specifications and few sanctions.

Interviewee accounts reflected ambivalence over the benefits of incentivising through LESs, particularly over the longer term. Over the course of the project there was also evidence of a shift from the use of LESs

to the use of contractual flexibilities and more rigorous performance management of primary care. Interviewees thought it important that levers for health and well being formed an integral part of contracts rather than incentivised 'add ons':

'Because we have ended up in the situation where we have lots of little LESs or contracts that actually we're not performance managing, we don't know what they're delivering in terms of quality, and ... you can't tell the difference between what was previously happening and what wasn't. So we've tried to withdraw from those services. Whether I think we need to in the future I think the answer to that is yes, but it goes back to we need to be much better then about how we performance manage and write those contracts.' (DPH, Phase 2)

The fact that some practices carried out the same activities for which other practices were being incentivised meant that LESs were being used to address variability in the level of care provided through general practice. It was argued that engagement could prove a more successful route:

'I don't think financial incentives are necessary, I think it's really important to get engagement at a local level first of all ... with our vascular risk policy there is a scheme that will come into effect from next year so that will be focusing on specific areas of our borough. But other GP practices will still be doing those vascular risk assessments without a financial incentive because they do understand how important those things are. So I don't think you necessarily need to throw money to fix the problem.' (PEC Chair, Phase 2)

Moreover, LESs could often be introduced without regard to effects on increased activity in other parts of the health care system. An example was given of a 'falls LES' that failed because there was not the capacity to respond to referrals from these practices:

'If you put an incentive in one part of the system how's the rest of the system aligned to that? Because you can do all the proactive work in the world but if the rest of the system has still only got the capacity to respond to reactive and it can't refocus quick enough it doesn't take long for the system to get clogged.' (Director of Strategic Commissioning, Phase 2)

Many interviewees argued that the most appropriate form of incentivisation depended on the nature of the service and those who were to deliver it and no broad generalisations could be made. Nevertheless, a number of case study sites were seeking to amend, reduce or package LESs in various ways. The latter could include combining or clustering related LESs into a Service Level Agreement with general practice networks and including a more detailed specification of what was required as part of the LES. There was also the suggestion that LESs as currently conceived did not encourage an integrated approach which would be incentivised through budgets related to care pathways. Other PCTs were clear that there would be fewer LESs in future as they would gradually be replaced by different contractual arrangements. There needed to be more clarity about what was included as part of the baseline GMS contract, for example.

Interviewees in a number of sites were also not in favour of individual incentives because it detracted from the values of partnership. Instead of pursuing a transactional approach, as reflected in the LES and also the QOF, it was argued that there should be a new approach to partnership and although this would probably be reflected in a PBC incentive scheme and a LES, the important issue was to change the culture rather than adopt a top

down approach to contract management. One interviewee described it as follows:

'And actually we, as a PCT we don't treat them as partners in the process of delivering health care, we try and treat them as if they're effectively an employed part of the health care system, which they're not It's about saying if you want to come into a slightly more partnership model with the PCT, we will do this, we will enhance your GMS baseline, but we will expect you to deliver it to a higher level, and we will expect you to work jointly with us to deliver the targets.' (PEC Chair, Phase 2)

In other cases, as mentioned above, it was decided to try and channel contracts through networks of GPs rather than incentivise individual practices, in order to encourage standardisation of care, improve performance management and provide support for weaker practices. Information which allowed practices to benchmark their performance was also a key factor in motivating practices to improve their performance.

The interviews also demonstrated differences in the extent to which DsPH were involved in incentivising primary care to provide health and well being services, through LESs or through APMS contracts. This was sometimes described as the province of separate departments concerned with primary care commissioning and outside their remit. Given that LESs are both optional and a main route for incentivising additional preventive services, there may be risks to preventive services if they are withdrawn.

8.2.3 Incentives within contracts for acute providers

Payment by Results (PbR), is steadily replacing the previous system of block contracting⁹⁹ and, in 2008/09, it covered 45 per cent of all secondary health care purchased by PCTs.

Empirical evaluations suggest that PbR has led to modest increases in activity, with little or no detrimental impact on quality.^{112, 113} In terms of provider behaviour, there is evidence of increased efficiency (by lowering providers' unit costs), limited evidence of changes in the pattern of coding – miscoding caused both over- and under-funding, with no systematic pattern – and encouraged providers to improve financial and information technology management and overall planning approaches.^{112, 114} In terms of transaction costs, PbR has lowered the costs of price negotiation, but costs associated with volume control, data collection, contract monitoring, and contract enforcement are higher.⁹⁹ These changes in transaction costs affect both providers and commissioners. It has been argued however that PbR incentivises hospital activity rather than health outcomes and can work against a focus on preventive care and collaboration, a view reiterated below:

'The difficulty can be countering the perverse incentives in the system, and one of the biggest ones of those is payment by results, period. It's just, in terms of commissioning for health and well being, payment by results is almost a disaster, because it's not payment by results at all, it's payment by activity. And if you just think about it with the pure accountancy hat on from a hospital point of view, if they're paid for admissions, then there's no incentive to reduce admissions.' (DS, Phase 1)

One interviewee identified tensions between PbR and PBC:

'Payment by results and practice-based commissioning, if working effectively, are going to divide primary and secondary care working effectively together, and we need to work out very carefully how to not let that happen locally.' (PEC Chair, Phase 1)

Both primary and secondary preventative services are currently outside the scope of PbR.¹¹⁵ However, the West Midlands SHA¹¹⁶ has introduced mandatory tariffs for lifestyle risk management services such as health trainers, smoking cessation clinics, and expert patient programmes. The aim is to address supply side barriers by providing financial incentives to expand provision of preventative services. Providers accredited by a PCT are free to recruit participants and provide services in line with a detailed service specification. Providers must also provide activity information for audit purposes. Tariffs are payable for achievement of specific outcomes, or intermediate outcomes, rather than for activity. For example, smoking cessation tariffs are payable for 4-week quitters.¹¹⁷

Payments are adjusted to reflect efforts to recruit 'hard to reach' participants (to discourage adverse selection, or 'cherry picking'), such as people from minority ethnic groups or from the most deprived areas. There are also higher payments for smoking cessation by pregnant women.¹¹⁷ Transition payments are available (to reduce the risk of short-term financial instability), and auditable codes of conduct are written into contracts (to discourage gaming and to help align principal-agent incentives).¹¹⁶ This regional experiment was under review at the time of writing.¹¹⁵

One of the focus groups, conducted as part of the study, discussed tariffs for health improvement services:

'But if you think about smoking cessation services, weight management services, these are health wellness services, is what I call them, and if you have a tariff concept in wellness services, you'd actually really focus people's attention on delivering it cost effectively, commissioning it cost effectively, and I think it changes behaviour. So I think there are some policy incentives, if you like, that we really haven't explored fully in public health terms.'
(Regional focus group)

The tariff could be weighted towards the 'hard to reach' populations with the aim of actively encouraging identification and targeting. However, there was some dispute in the focus group whether this approach would be effective in all areas, especially where there were high rates of population turnover. The amount of time to be spent on reaching the most 'hard to reach' populations was also questioned in respect of other demands on services. The national survey asked whether tariffs had been included in contracts to reflect health improvement targets. Around 39 per cent of PCTs said no whilst only 14 per cent said yes. Of those that said tariffs were included, most were using it for smoking cessation.

CQUIN and incentives through the acute contract

In the NHS Operating Framework for 09/10¹¹⁸ new incentives were introduced to link payment to quality improvement in 2009/10 contracts through the commissioning for quality and innovation initiative (CQUIN).

Approximately a quarter of PCT interviewees (12) discussed the idea of commissioning for quality but this was currently being considered only in

respect of acute and mental health service providers. However, in discussion, the complexity of introducing such payments emerged and reflects the 'monitoring intensity' and 'incentive intensity' principles summarised in Table 6:

'Actually it wasn't always straightforward to think what those quality indicators could be. It was really easy to think of what the topic matters were, you know, there are things that are very important to us, but actually nailing them down to something that (a) can be measured, (b) can be measured without too much added grief, (c) where there wasn't a get out of jail free card for the provider in the sense that oh well, you know, actually we didn't perform well but actually that wasn't our fault, that was somebody else's fault, you know, you could be specific about what the provider's role was in that part of the quality measure, and then setting a realistic target for the improvement of the quality, is actually really difficult.' (Director of Strategy, Phase 1)

CQUIN was generally focused on better health outcomes for patients, and not on a preventative agenda, although there was evidence of using CQUIN (or quality indicators which predated its introduction in acute contracts) to promote preventive services. Examples were given of incentivising smoking cessation services (for maternity services or screening all elective patients for smoking status) or Accident and Emergency Departments sharing information on alcohol-related injuries with other agencies. Recent changes at a national level would ensure that the tariff paid to providers would reduce while the proportion rewarded through CQUIN would increase, and it was considered this should lead to CQUIN tariffs which were better specified. However, it was pointed out that these targets were difficult to monitor and it was possible that some interventions, such as smoking cessation, could be better located in primary care.

8.2.4 Local Area Agreements

LAAs are a jointly agreed delivery plan for achieving the aims of the Sustainable Community Strategy. Rewards are available (through pump priming and a performance reward grant for achievement of stretch targets). It has been argued³⁴ that financial incentives are small in relation to the administrative input involved - and less than in previous LAA rounds. Changes in the reward structure mean that individual departments will no longer be individually rewarded, but the reward will be shared by all partners involved, encouraging the pooling of budgets. Although LAAs were considered important for promoting a health and well being agenda and partnership working, financial benefits were not discussed by interviewees.

8.3 Incentives outside contracts

While contracts and transaction costs have been the subject of research, many financial incentives fall outside a contractual framework. This applies to Spearhead status and rewards to practice based commissioners which are discussed in turn.

8.3.1 The impact of Spearhead status

One of the research questions we addressed was the impact of Spearhead status on commissioning in PCTs. Half the case study sites were Spearhead PCTs or contained Spearhead areas. The funding formula for PCTs includes a health inequalities element and Spearhead areas have more to spend than the England average.¹⁵ However, it is difficult to identify how much has been spent on narrowing health inequalities and reducing the causes of ill health.

Twenty PCT interviewees and four PBC interviewees commented on the impact of Spearhead status. Although knowledge was limited among practice-based commissioners, both practice-based commissioners and PCT interviewees agreed that Spearhead status did not impact on or change the way in which PCTs worked - striving to reduce inequalities was something they would be doing anyway and Spearhead status was seldom referred to:

'The impact, I'm not sure it's had any impact whatsoever. Well the point is do you need to be a Spearhead to know that you've got to get to grips with health and well being and prevention. You're just going to do it anyway... If you said is our work around health and well being and prevention delivered because of being a Spearhead, no, it would have been done anyway.' (Deputy Chief Executive, Phase 1)

While the extra funding associated with Spearhead status was acknowledged, none of the interviewees could give examples of how Spearhead monies had been spent to reduce inequalities or of projects funded through Spearhead resources which had then been mainstreamed. It had simply formed part of the baseline:

'I'm sure any Spearhead money that ever did come through - again I wasn't here - has disappeared. We certainly haven't got any earmarked funds, I'm not aware of anything that says Spearhead money here.' (DPH, Phase 1)

A small number of PCT interviewees felt Spearhead status had raised their PCT's profile and increased the focus on public health and inequalities including at board level. In some instances, it had aided the targeting of resources to areas of greatest need (though some argued that they would be doing this anyway). One interviewee stated the PCT had set more challenging trajectories for targets and an additional interviewee stated it had encouraged partnership working. Two PCT interviewees felt there was a lack of accountability for the performance of Spearhead areas.

'I certainly don't feel that anybody at the SHA has ever been held to account, in any way, shape or form, for the Spearhead area making different progress.' (Chief Executive, Phase 1)

And in another site:

'I don't think there's any mechanism for particularly sharing amongst Spearheads except to compare yourselves. I don't think there's any sort of review of how performance is against those Spearheads or any kind of real feeling about what the role of local government is within that.' (DPH, Phase 1)

In order to locate these findings in a national context the survey asked if having Spearhead status acted as an incentive to focus on health and well being. The results from 43 responses received were split as follows. Over half saw little or no effects.

Not at all	27.9 per cent (12)
Slightly	27.9 per cent (12)
Quite a bit	32.6 per cent (14)
A lot	11.6 per cent (5)

These results reflect the lack of a contractual element and of routine performance monitoring in relation to this financial incentive.

8.3.2 Reward systems for practice-based commissioning

PBC is encouraged through a series of rewards, first for involvement in PBC (often through a PBC LES), and second through being able to use 70 per cent of any savings (Freed up Resources (FUR)), derived from the reconfiguration of care or efficiency savings for developing services to meet local health needs. This depends on PCTs agreeing a PBC business plan, alignment of the plan with the strategic objectives of the PCT and availability of resources. Difficulties in PBC have been well documented¹¹⁹ and different kinds of reward element were used in a number of PCTs to encourage clinical engagement. For example, the PBC LES could also require monitoring of non-elective activity, public involvement and management of budgets. It could simply refer to time spent in which case it could be interpreted as due payment rather than as an incentive. The extent to which FUR was targeted towards health and well being was one of the questions addressed through the project.

Although this study did not focus on the development of PBC, issues related to the governance, development and orientation of PBC clearly influence the extent to which PBC is likely to become a force in commissioning for health and well being for practice populations. Also important is the extent to which PBC is involved in deciding commissioning priorities as opposed to simply commenting on them or reflecting them in their business plans.

This section begins by summarising views about incentives for PBC before looking at how practice-based commissioners in our study engaged with health and well being services.

Views on PBC incentives

There was some scepticism about the role of incentives in encouraging practices to become involved in PBC in both first and second phase interviews. It was argued that it kept them away from their practices and there was little profit to be gained. As one interviewee commented:

'The most remarkable thing about practice-based commissioning is that anybody does it at all, because there's no profit it... and certainly no personal gain.' (DS, Phase 2)

FUR appeared a substantial incentive in theory, as PCTs could allocate 70 per cent of FUR to PBC for developing services to meet local health needs. In practice, however, this was dependent on the financial situation of the PCT, and influenced by the extent of overspend in other practices, as well as by the approach of the individual PCT. All such savings could be withheld

and were being withheld at the time of the interviews in a number of the case study sites. This meant that there was little incentive to develop business plans. One interviewee commented that:

'We did have a number of GPs quite engaged in practice-based commissioning and that all fell apart in 2007/8 because they were offered the incentive to join up but then they were told during the course of the year there wouldn't be an achievement payment. So there was basically a breakdown in the relationship between the PCT and the practices where they felt, if it's not too strong a word to say, betrayed.' (Director of Primary Care Commissioning, Phase 1)

The effectiveness of FUR as an incentive was further questioned by a number of interviewees, especially given the annual planning and monitoring cycles which made 'investing to save' difficult. Many health and well being initiatives were small-scale pilot projects and often unable to demonstrate effectiveness in a short time period. It was difficult to commission services 'off the shelf' or be clear about expected outcomes. In the same way, it was difficult to quantify savings from health promotion or public health interventions and use these resources elsewhere. In contrast, it was clear how money could be released through service reconfiguration. Both the 'pilot nature' of initiatives and the lack of recurrent funding were considered significant barriers to engagement with a health and well being agenda. Moreover, extra resources could be required to make savings which were then used to commission additional services:

'If I'm going to start saying well I will set up a new service internally within the practice to look after all these people in a much more assertive way, and take one of the doctors out of the surgery to do all that, that is, or I'm going to sit down and pull all these people and review their medication in a much more rigorous way, there is no finance to support that. If I'm going to improve my access sufficiently so that people don't go to A&E, it saves all the money on the budget, but actually I've employed more doctors and nurses to do all that sort of stuff, and there's no incentive in the system.' (PEC Chair, Phase 2)

In other cases, however, FUR was seen more in terms of a *quid pro quo* for demand management in primary care, in the context of a collaborative approach, rather than directly related to the resources saved through effective demand management:

'I think we need to see it as a process of 'we've saved the PCT some money so they give us some to do something else' really, rather than thinking, you know, that's a tenner so we can spend a tenner. I don't think it's helpful to think of it in those terms, and I would hope that the PCT would support through whatever mechanism a good work that was suggested regardless of freed-up resources.' (PBC lead, Phase 2)

In one site, a more strategic approach had been adopted to the deployment of FUR, and an element of FUR had been made recurrent in the first year so that redesign work in line with strategic objectives could be completed. Pooling arrangements were also in place to allow the development of larger schemes.

From a system-wide perspective it was argued that potential savings from service redesign were often less than assumed. Even if progress was made in achieving earlier discharge, for example, new patients would take their place and could be costlier making it difficult to release resources from the acute sector. While there were incentives for PCTs to manage demand

through PBC, as failure to do so would threaten their financial viability, one of the aims of NHS Trusts was to increase their activity and this resulted in a fundamental imbalance and tension inherent in the system. The impact of specific incentives was reduced if incentives in the system worked against each other or failed to cohere. One interviewee commented:

'At the other end of the spectrum you've got Foundation Trusts who as a requirement of their operating licence with MONITOR requires them to produce a surplus. So they have no incentive to do other than to suck more and more work into their hospital or whatever their institution is. Now there is a complete absence of any notion that these things are aligned.' (DS Phase 2)

Innovation budgets, which provided funds for developing and piloting ideas, were used in two of the sites and were seen as an incentive to participate in PBC and engage in health and well being activities. A further PCT decided savings would be pooled and a 50/50 split would be implemented. As a result 50 per cent of the saving would be returned to the practices which had made the savings for them to develop plans on how this could be spent locally while the other 50 per cent would be spent on developing pooled bids. This was seen as an incentive through reducing financial risk and strengthening partnership working and occurred in a site which cited strong clinical leadership and collaboration with practices.

Although many questioned the current emphasis on financial incentives, it was agreed they acted as a lever for achieving strategic goals. However, they formed only part of the picture and while the majority of interviewees considered them a spur to action, they needed to be complemented with PCT support in order for change to occur. Development support, leadership and management skills were all important as was benchmarking across practices, demonstration of success and peer approval.

While there was one example in the case study sites of FUR being used to set up a health café, engaging with a wide range of partners, the more common finding was that PBC involvement with the broader health and well-being agenda or with identifying the needs of their localities was minimal. One interviewee commented:

'But I think by and large practice-based commissioning has not really got to the health and well being agenda. I think it's been very much about service delivery and, you know, community assessment services or joint problems, that kind of thing.' (DPH, Phase 2)

The national survey did not identify many examples of practice-based commissioners commissioning health and well being services from themselves or from other providers. Those that could identify examples of this commissioning strategy cited weight management, sexual health and enhanced health check (from themselves) and exercise trainers, dermatology services and a traveller outreach project (from other providers). When asked how PCTs were encouraging PBC to commission health and well being services, the most popular method was through FUR (52 per cent of 82 responses), followed by the use of an innovation fund (34 per cent).

8.4 Experimental economics and individual incentives

Experimental economics provides approaches to decision-making and individual incentives. These are discussed before focusing on the research on individual incentives and views from interviewees.

8.4.1 From decision-making to nudge economics

Empirical evidence suggests that as tasks become more complex, individuals adopt simplifying decision-making strategies, such as the use of heuristics (rules of thumb) ¹²⁰ (p 193). These simplistic approaches can produce decisions that are systematically biased, but are nonetheless often used, even when the stakes are high or financial rewards are available for making the 'right' decision.¹²⁰ There are three types of heuristic that economic experiments show can lead to predictable, systematic errors.^{120, 121}

- (1) The availability heuristic: people estimate the frequency of a class by the ease with which they can recall specific instances of that class. This may be due to internal recall bias, or to external factors such as media coverage. For example, people overestimate the incidence of highly publicised causes of death.
- (2) The anchoring heuristic: judgments are based on information we already hold, or are given ('anchors'). Answers depend on the method used to elicit them.¹²¹ For example, if commissioners are interested in finding out willingness to pay for swimming sessions or weight loss clinics, they should be aware that responses will depend on the order in which price options are offered.
- (3) The representativeness heuristic: judgements about the likelihood that a particular event or case belongs to a certain class, based on the perceived similarity of the case to the judge's stereotype of the class. For example, awareness that random events occur is displaced by the immediate 'evidence'. Experiments support the view that individuals tend to give too little weight to prior information and too much weight to new information.¹²⁰ (p.154)

In addition to biases associated with heuristics, other systematic errors can occur during decision-making such as the 'sunk costs' effect where judgement may be based on costs already incurred. For example, if a fixed payment has to be made to go along to weight management classes, participants may be more likely to attend than if they just pay for each class attended.¹²⁰ (p.193) 'Prospect theory' offers an alternative descriptive model of economic behaviour to that proposed by game theory. According to prospect theory changes in wealth are more important than final outcomes; gains are treated differently to losses; and outcomes with certainty are over-weighted relative to uncertain outcomes.¹²⁰ (p. 5-6) Therefore willingness to pay and willingness to accept may differ: individuals may be willing to pay a lower amount to receive services that are not currently provided than the amount they would be willing to accept

to compensate for the loss of identical services that they currently enjoy. This discrepancy can be harnessed when designing health and well being services, a topic addressed by 'nudge economics'.

'Nudge economics', ¹²¹ a recent experimental approach, considers how to make it easier for individuals to choose what is best for themselves, their families, and their society. It has parallels with 'making healthier choices easier choices' ⁸⁴ a mainstay of health promotion strategy. ¹²² Drawing on the evidence that individuals may make systematic errors in their decisions, nudge economics describes the ways that the 'choice environment' can be designed to encourage ('nudge') individuals to make beneficial choices without restricting freedom of choice. The process is known as 'choice architecture' and essentially involves incorporating human factors into design, working with human 'frailty' rather than trying to override it. Examples of nudges include default rules, feedback mechanisms, incentives (market-based or socially created), structure choice systems, social cues, frames, and transparent designs. ¹²¹

Loss aversion helps to produce inertia, a strong desire to stick with the status quo or to 'do nothing'. ¹²¹ This is particularly the case when benefits and costs are separated in time: people may need encouragement to invest in pensions or health, because the costs are immediate but the benefits are attained only in the distant future. ¹²³ Policies need to address this imbalance by either increasing present benefits or decreasing present costs of healthy options. Inertia means that if individuals are offered a choice with a default option, many will 'choose' the default even if it is not in their interests to do so. Well-designed default rules can act as powerful nudges to encourage better choices. Feedback mechanisms are another way of improving performance by providing positive feedback when performance is good and providing information on mistakes. For example, visual displays of 'calories burned' on gym equipment provide positive feedback, helping to close the gap between current costs (effort) and future gains (fitness). Incentives can be financial or non-financial. In markets, incentives are an inbuilt part of the price system, working to match supply and demand. However 'incentive conflicts' can arise. Thaler and Sunstein ¹²¹ recommend that four key questions need to be considered about incentives:

- Who uses?
- Who chooses?
- Who pays?
- Who profits?

The answers to these questions can help highlight the differing and conflicting incentives within a service and appropriate adjustments can be made to help align the incentives. ¹²¹ For example, financial incentive schemes may comprise payments for weight loss or for smoking cessation. ¹²⁴

Social marketing can also draw on these techniques to achieve particular behavioural changes.

8.4.2 Incentives for public health and individual behaviour

Individual-level incentives can also be used to encourage healthy behaviour.^{125, 126} Early evaluations suggest that incentives have more impact on participation in health promotion programmes than on changes in lifestyle behaviours.¹²⁶ There is a growing body of evidence that financial incentives targeted at individuals can effect changes in short-term behaviour – such as smoking cessation, physical activity or weight loss – but it is less clear that changes persist after financial rewards have ceased.⁹⁴

There has been an increase in PCTs offering incentives to consumers to carry out lifestyle change. Incentives can also be ‘negative’: some are broadly targeted, such as taxes on alcohol and tobacco, whereas others may penalise individuals, such as insurance schemes that increase premiums for those who do not participate in screening programmes. Taxes may help address health inequalities, if a fixed increase in price has a greater impact on demand for lower income groups. However, some argue that penalties imposed on individuals can risk exacerbating existing health inequalities and heighten the potential for coercion.¹²⁷ To help ensure that incentives are ethical, several steps can be taken. These include involving users when designing programmes; providing a choice of health promotion tools; and allowing opt-outs when there is good cause.¹²⁷ Health England echoes the importance of considering the implications for autonomy when evaluating incentive schemes.⁹⁴ Other criteria for assessing incentive schemes listed by Health England include effectiveness, cost-effectiveness, equity and feasibility. Based on these criteria, matching grants for commissioners and direct payments to individuals were rated most highly of the schemes considered. Other criteria that may be relevant for commissioners to consider include safety (e.g. risks of unintended consequences) and ‘efficiency’ or budgetary impact.¹²⁴

Individual incentives for behaviour change

Some case study sites were offering incentives to individuals to promote behaviour change, sometimes related to meeting targets. Incentives included the use of loyalty cards with points added for healthy behaviours which could be converted to benefits through a local company set up as a social enterprise, and cinema tickets in return for Chlamydia screening. Interviewees considered that incentives were more effective for screening than for long-term behaviour change. Incentives for stopping smoking in pregnancy had been tried in one site but proved unsuccessful.

8.5 Incentives in context

Despite misgivings over the current emphasis on financial incentives, interviewees nevertheless considered incentives provided a flexible lever for achieving strategic goals and addressing shortcomings and inflexibilities in

the GMS contract. However, a public sector ethos and 'softer' motivational skills were also important and some considered that financial incentives could undermine intrinsic motivation (the 'crowding out' problem). Incentives needed to be coupled with longer term changes in mainstream services. Although often intended to kick start changes, there was a danger they would be seen as a permanent financial resource:

'But, you know, it's about funding change. But then the change becomes the mainstream. If the change doesn't become the mainstream way of working, then you're stuffed, because you're either left with a decision of well we're going to have to incentivise this forever, or we stop incentivising it, and it stops happening.' (DPH, Phase 1)

Failure to meet the requirements of performance management regimes or sanctions arising from poor ratings also acted as incentives to improve performance. However, incentives could lead to perverse consequences and there were possibilities of gaming, paying for services which might have been provided anyway, and an over reliance on incentives to improve performance and quality of care.

'Solidaristic' incentives could prove of more importance than individual incentives. Non-financial incentives were emphasised by a number of interviewees and included earned autonomy of practice-based commissioners; increased choice as a method of encouraging providers to improve local services; gaining peer approval; gaining support from the PCT; performance management; and the feeling of 'doing the right thing' for local populations.

As mentioned earlier, the impact of individual incentives was reduced if incentives in the system conflicted or were misaligned. The consensus of opinion was that PbR worked against commissioning for health and well being and it was difficult to release resources to reinvest in preventive services. A number of interviewees considered that 'collaborative commissioning' was a way forward and described a number of options under debate. One example was to involve primary and secondary clinicians within localities based around hospitals, working with social services to manage a budget. At the same time, there was uncertainty given political differences in the extent to which budgets could or should be devolved. Another was to provide a budget with a local network of GPs (through a Service Level Agreement) for a specific pathway of care which would also incorporate preventive services. The networks were also aligned with local partnership structures to encourage broader partnership working, particularly with borough-based services. This was described as follows:

'It'll enable us to do two things that we haven't really been able to do, previously, and that's work well at a local level on relatively small-scale things and do that by getting health and well being better integrated within primary care.' (DPH, Phase 2)

Another proposition was to establish devolved budgets for GPs to manage their population's health needs, combined with more control of community services, although this model would need to be piloted in order to identify optimal size of budgets and establish the nature of collaborative arrangements across PCTs in order to share risk. It was argued in one site that new kinds of contract were required, based on categories of care and

drawing on more sophisticated data than currently available through programme budgeting.

Although care pathway development is a common theme, these approaches have different implications for the extent to which PBC becomes more involved in the health and well being agenda or with local partnerships outside the acute sector.

Looking forward, some interviewees saw distinctions emerging between 'strategic commissioners' (PCTs) who set and monitored outcome measures and their 'accountable providers' who could themselves commission elements of the care pathway to achieve strategic outcomes. Children's services could integrate commissioners and providers across health and social care and 'risk sharing' across commissioners and providers was being discussed. Where PCTs had formed clusters to provide acute services commissioning the point was made that a public health presence was still needed if a return to 'old style' procurement was to be prevented.

8.5.1 Contractual flexibilities and performance monitoring

Although there was evidence of declining enthusiasm for using incentives in phase one interviews, by phase two, there was a shift in emphasis towards the following:

- (a) PCTs requiring a clear notion of what GPs should be providing as part of a core contract and therefore which areas needed to be incentivised or separately funded.
- (b) Concentrating on contract specification and the performance management of GP contracts and using all available contractual levers.
- (c) How far networks of GPs, rather than individual practices, should be incentivised.
- (d) The extent to which contractual arrangements with GPs could be placed on a different footing, such as APMS, so that performance management arrangements flowed from the nature of the contract.

PCTs could exploit contractual flexibilities through APMS, PMS and SPMS. PMS agreements provided essential services, with greater freedom to meet the health needs of local populations. PMS contracts were restricted to medical practitioners while APMS contracts offered greater flexibility allowing services to be commissioned from a wide variety of sectors, including commercial organisations, voluntary and charitable organisations, social enterprises, mutual providers and public bodies. Their use was becoming increasingly popular as it allowed commissioners to clearly define what was needed from the outset. However, core contracts were already in place and re-commissioning through APMS and PMS could only take place when these contracts came to an end.

The national survey demonstrated similar percentages of GPs with GMS and PMS contracts but only an average of four per cent of GPs with APMS

contracts across the 43 PCTs that responded to this question. We asked whether PMS and APMS contracts were being specified or reworked to explicitly address health and well being. Around 22 per cent of PCTs said no and 49 per cent said yes or had these contracts under review. Few gave examples, however.

Interviewees were often uncertain over the balance to be achieved across incentives and contracts as this could be influenced by political changes. There was far less enthusiasm for APMS among practice-based commissioners in our case studies, as contracts were considered too short-term. In any event, it could be difficult to remove contracts without leaving populations at risk. While it was recognised that performance management had been neglected, the point was also made that practices were not adequately involved in strategic discussions but 'bombarded' with operational and transactional information which originated from different parts of the PCT. There could be separate activities for medicines management, contracts or clinical governance which all took place in separate silos:

'And there was a whole process whereby bits of the PCT that related to general practice were all in little silos. There was sort of medicines management, there's the contract, there's clinical governance, there's, you know, all those sorts of things were all in completely separate silos and we had to bring them together.' (PEC Chair, Phase 2)

PMS contracts were described as disappointing and not adequately exploited and there were a number of attempts to ensure that the PMS practices were providing value for money. Contracts needed to be explicit and include health improvement targets.

As mentioned above, the emphasis was shifting towards better performance management of PMS contracts and the added value they might bring, and better monitoring of QOF payments, both recognised as relatively neglected areas. PCTs were increasingly holding practice-based commissioners to account in relation to reducing referrals, non-elective admissions, prescribing budgets and attendances at Accident and Emergency Departments. Finally, there was increased interest in APMS contracts, especially for new contracts, which might include incentives or penalties for not reaching targets agreed in the contract. There would be a core GMS contract with an APMS contract covering all other services. Such contracts could also incorporate preventive components.

Despite the importance of incentives and contractual levers there was some variation in the extent to which DsPH were engaged with this aspect, which often fell under the aegis of a different part of the PCT devoted to primary care contracting.

This chapter demonstrates that individual incentives, such as FUR are limited in their potential to promote health and well being, that the balance between incentivisation and contract specification (including the nature of core contracts) is changing and that a transactional approach may undermine engagement and local involvement. PbR incentivised increased activity and there were few incentives for partnership governance. New approaches to devolved budgets were being considered as a way to increase

the focus on outcomes. Newman,¹²⁸ quoted in Davies et al.,²⁶ distinguishes between 'solidaristic incentives' reflected in self and in network governance and 'individualised' incentives reflected in hierarchies and market governance. Changes in this balance were being negotiated in a number of our case study sites.

9 Prioritising investment for health and well being

'We must reorientate our health and social care services to focus together on prevention and health promotion. This means a shift in the centre of gravity of spending.' (*Our Health, Our Care, Our Say* ⁶ (p.9))

There is a long standing aspiration to 'move upstream' and invest for health, through re-orientating health care systems towards preventing ill health and through working across a wider public health system to address wider determinants of health. This chapter begins by describing the policy context (9.1) and then draws on both interviewee accounts and survey data to illustrate influences on PCT priorities (9.2), investing for health and well being (9.3) and methods for prioritising investment (9.4). Subsequent sub-sections discuss economic evaluation of public health in the light of the NICE approach; views on preventative health spend (PHS); and benefits and limitations of prioritisation tools currently used by commissioners. The usefulness of prioritisation tools in general is assessed against the range of criteria outlined in relevant WCC competencies, with particular reference to issues arising in prioritising health and well being. Appendix five provides more detail on prioritisation tools.

9.1 Policy context

A number of reports have drawn attention to the implications for the NHS and for the wider economy of failing to 'invest for health'⁹ and the need for the NHS to refocus, with performance management systems and regulatory arrangements aligned accordingly.¹⁰

The *Commissioning Framework for Health and Well Being* ⁷ which built on *Our Health Our Care Our Say*,⁶ was designed to help commissioners achieve a more strategic orientation towards promoting health and well being, reflected in a stronger focus on commissioning services and interventions across health and local government (para.1.1). As part of this there would be flexibility in 'shifting resources to where investment can have the greatest impact on current and future health and well being needs' (para. 1.11). Subsequently the importance of identifying resources spent on health improvement was emphasised ¹³ (a theme subsequently pursued through Health England)¹²³ as well as of developing programme budgeting (PB), which currently did not allow for 'sufficient understanding' of spend on preventative programmes and services. Despite the scale and cost of preventable ill health, methods for prioritising prevention within the NHS and in partnership with local authorities and others, remain poorly developed. Attention is being directed to estimating the financial and non-financial impact of health improvement activity.^{88, 129}

Ethical, practical and methodological issues in priority-setting have been well rehearsed, but the need for commissioners to develop such skills gained a higher profile through WCC and, in particular, competency six:⁵

'To prioritise investment of all spend in line with different financial scenarios and according to local needs, service requirements and the values of the NHS This will include investment and disinvestment plans to achieve health gains and address areas of greatest health inequality... . Part of the requirements for meeting level four in the WCC assessment scale (the highest level) is that 'the PCT invests for longer-term health outcome gains and can quantify impact.' (p.80)

Competency eleven⁵ is related, focusing on efficiency and effectiveness of total expenditure and on the 'core purpose' of commissioners, that is:

'to make sustainable trade-off decisions and sound investments across all spend, to deliver the highest level of health benefit and quality of care for a given level of spend along each care pathway. Robust analysis of spend and its impact on health benefit enables PCTs to make well-informed investment decisions.' (p.85)

Prioritising investment and making decisions over disinvestment are now key tasks for commissioners. This raises questions of how such decisions are reached and the extent to which they reflect the underlying values of the commissioning organisation or longer term health gain. Cribb⁶⁸ identifies common patterns of 'ethics avoidance' of challenges raised by public health decision-making. These include treating all issues as scientific technical questions subject to technical decision-making; accepting given frameworks of targets; and the notion of a public mandate, achieved through consultation.

It has been argued¹³⁰ that methods for priority-setting within the NHS need developing given a number of key challenges: how to manage a large number of decisions; how to ensure that priorities are adhered to; how to fairly compare different sorts of interventions; how to ensure that investments reflect priorities; and how to fully engage the wider NHS and the public. It is suggested that, as a minimum, priority-setting should consider programme goals across an entire patient pathway, including the protection of good health; disinvestment strategies; and how to move from reactive to proactive commissioning. This is key to commissioning for health and well being, which demands a proactive approach and investment over the longer term. NHS resource constraints from 2011 were likely further to promote strategies for efficiency and for disinvestment.

9.2 Influences on PCT commissioning for health and well being

There are many influences on PCT decision-making, including WCC, a public health-led approach to commissioning, NICE guidance, JSNAs, DPH reports, national targets and public consultation. The extent to which decisions reflect the values of the organisation are matters of governance and prioritising prevention depends on high level support. The PCT Board plays a key role in influencing values which inform the choice and weighting of criteria used in prioritisation processes. As discussed in Chapter 4, the majority of interviewees cited the Chief Executive, the DPH or the Board in

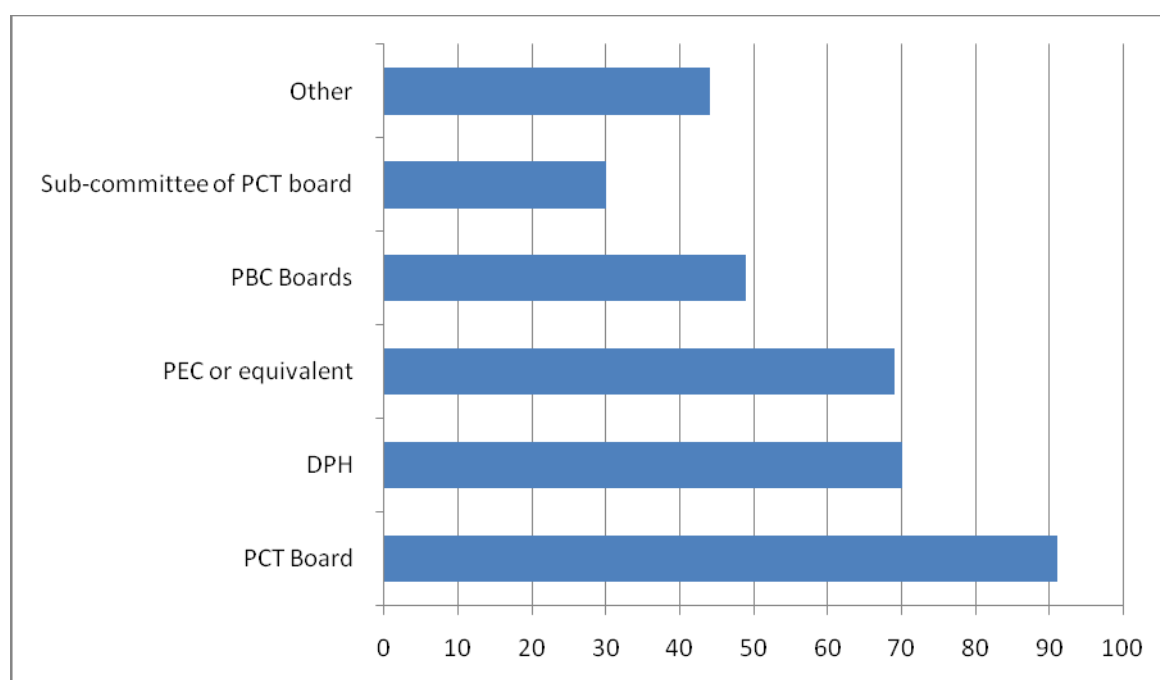
this respect, stating, for example, that Board commitment had been a significant lever for investing in health and well being:

'I've been here now nearly five years, and it's the only organisation I've ever come to where absolutely everybody, including the Board, believe that the only way that we're going to reduce health inequality and increase health and well being is to do things differently and to put more emphasis on upstream work, and they just get it.' (Deputy Chief Executive, Phase 1)

In another site, leadership of the Chief Executive was considered by most of the interviewees, including those in the VCS, to have driven the health agenda as a local leader in partnership working.

The national survey reflected this emphasis with 90 per cent of respondents locating priority-setting at Board level.

Figure 4. Deciding priorities for commissioning for health and well being



Sub-committees were also influential and the following were mentioned by one fifth of respondents as influencing priorities: public health or health and well being committees; commissioning committees; executive team meetings. Other relevant committees included partnership boards, financial oversight committees, PBC governance sub-committees, quality and governance committees and one WCC committee. In terms of the 43 'other' responses the bulk involved partnerships with local authorities, SHAs or joint commissioning arrangements with other PCTs. Two responses mentioned the role of public engagement strategies.

The influence exerted by practice-based commissioners and representatives of the public on priorities was variable, although PCT interviewees highlighted the importance of PBC being integrated into priority-setting, and of avoiding a tokenistic approach with the public. Some interviewees from PBC consortia saw PBC as largely centrally controlled, following PCT priorities with 'not a lot of room for any local ones'. While priorities might

have been agreed by PBC clusters, it was less clear how these decisions then influenced the PCT prioritisation process or the annual operating plan. In others, as described below, practice-based commissioners were highly involved:

'They were involved in determining what the criteria were, what the weighting should be. We basically involve them in everything. We have a very proactive PBC group ... we don't have to drag them to the table put it that way.' (Finance Director, Phase 2)

PBC leads were often involved in prioritising across a particular programme or pathway of care, examining the cost-effectiveness of each initiative, sometimes segmented by different groups and including some consultation with the community. The preventative element of pathway redesign was less developed, however. Redesign was also more difficult where aspects of the pathway were outside the remit of the commissioner or where information was required from other organisations.

9.3 Investing in health and well being

The survey showed that a majority of PCTs had increased their investment in health and well being in 2008-9 compared with 2007-8. The majority of those who increased investment attributed it to deliberate, strategic decisions taken at Board level, SHA level or in partnership with local authorities. Investment was directed to 'upstream' interventions, preventive care or reducing demand in secondary care, and sometimes implemented in the context of LAAs or other targets. A small number of PCTs had recently achieved financial balance enabling them to increase investment from a low baseline in 2007/8. However, there remained concern that investment was still inadequate.

According to the national survey, 70 PCTs claimed to have a strategy for shifting investment towards health and well being. We asked those 70 PCTs to identify how this shift was being achieved and Figure 5 illustrates that growth money and efficiency savings were deemed the most influential.

The 'other' strategies that were mentioned by respondents included local authority grants, QIPP and PHS, service re-design, programme budgeting, pump-priming investment and through the PCT's five year strategy.

Respondents to the national survey also identified barriers to commissioning for health and well being (see Figure 6). Pressure from acute budgets was emphatically viewed as the greatest barrier (by 84 PCTs). Financial pressures were next (59 PCTs), followed by an emphasis on short-term gains (50 PCTs).

Figure 5. Strategies for shifting investment

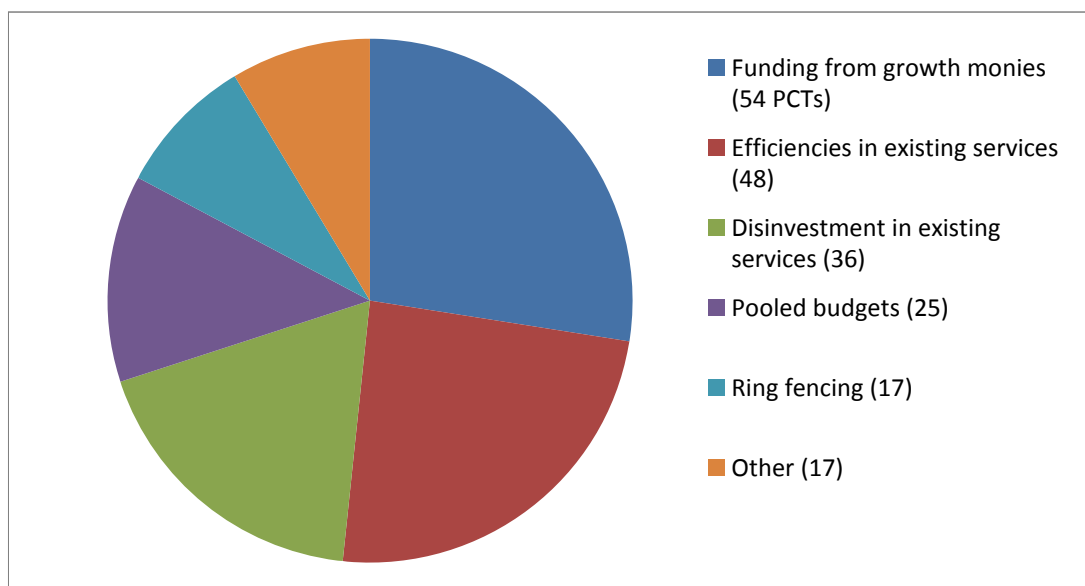
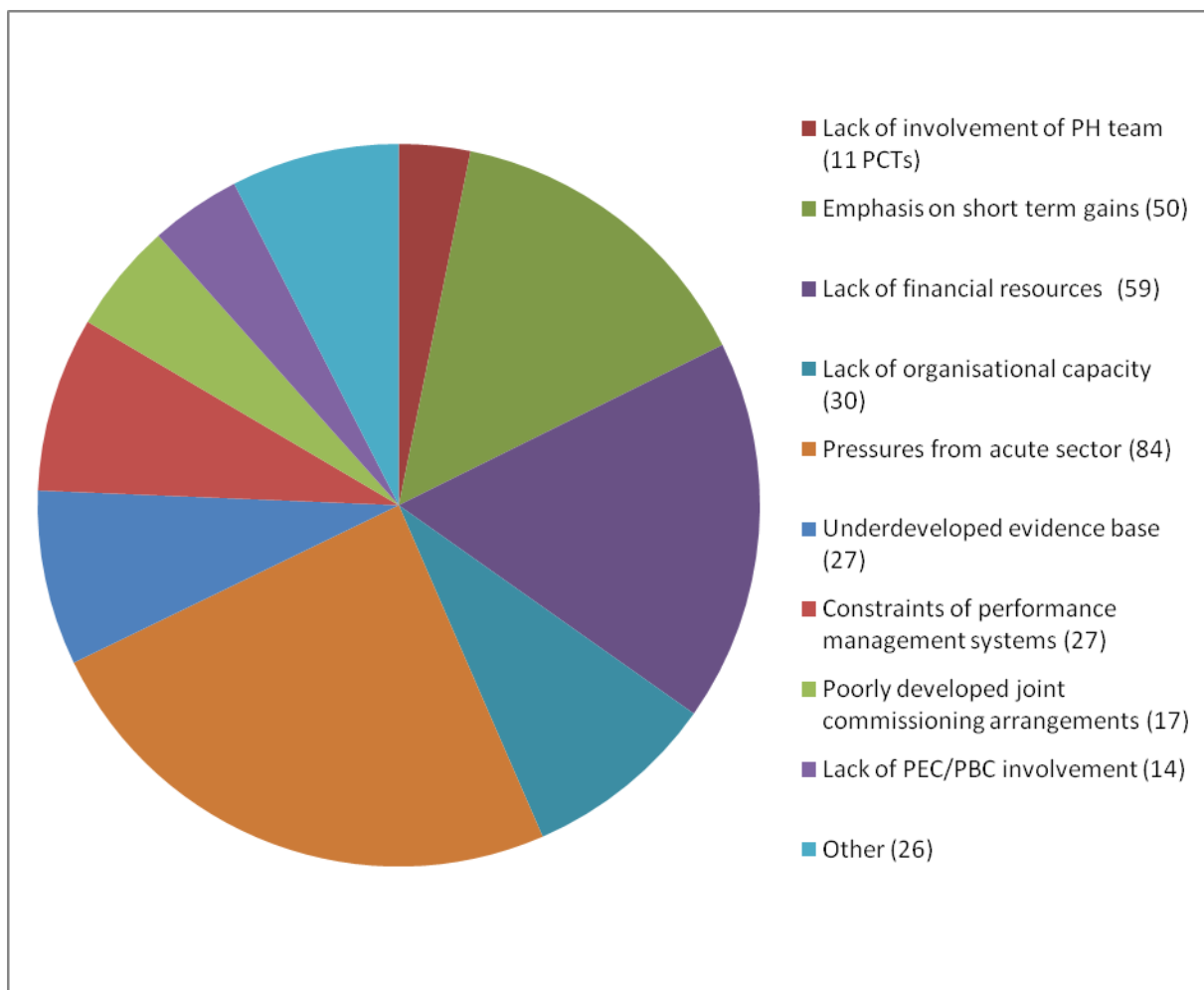


Figure 6. Barriers to commissioning for health and well being



First phase interviewees also emphasised the importance of growth money on the ability to invest in health promotion and in services to reduce health inequalities. In second phase interviews in particular, PCT interviewees described themselves as moving into a different mode as a result of the economic downturn, where prioritising investment of growth money would be superseded by decisions over disinvestment across total spend. Without disinvestment in acute care and reductions in prescribing costs, it would be difficult to fulfil strategic priorities, including those related to health promotion, even if return on investment in preventive care could be demonstrated. A number of interviewees noted that preventive services, including vascular checks and referral to Weight Watchers, had already been cut back:

'They will drop off the bottom of the list, and all we can do is continue to look for cost-effective ways of doing it but, you know, for us especially in the next year or two we've really got to target those areas where we can get most money back out of the system... unless we get those right now and get the big chunks of money out of the system, we won't be able to afford to do the health and well being agenda.' (Director of Quality, Phase 2)

Efficiency, value for money in more clearly specified contracts, and the development of tools for prioritising investment and disinvestment therefore gained in importance, although it was recognised that modelling skills were currently poorly developed. There was a widely shared concern to assess all interventions, including existing services, in relation to their outcomes for the population and their cost-effectiveness. In the same way, contracts would be tightly managed, there would be a greater focus on high-cost areas, and coding issues would be monitored in order to cost secondary care events more accurately. This approach also applied to new developments and to the reconfiguration of services intended to provide care closer to home. However, there was some scepticism about the ability to disinvest in services, an area where there was limited experience. There would be public and possibly political opposition, resistance from the acute sector or a risk of destabilising the local health economy. Reducing spending on health and well being was a 'soft option' given that it was 'invisible', benefits were long-term and, unlike changes to health care provision, it did not lead to a public outcry:

'You know, there are not ten thousand disappointed people who are fed up because they're not getting something to stop them getting bronchitis or lung cancer in five or ten years' time.' (DPH, Phase 2)

Others were of the opinion that the economic downturn would also prevent piloting innovative approaches which could be mainstreamed over the longer term if found effective. An additional problem was limited evidence on the effectiveness of public health programmes at a time of increased emphasis on presenting the business case for health improvement (further discussed in sub-section 9.4.1 below) not just for new initiatives but increasingly to preserve funding for existing services.

While this was the predominant view it was also argued that commissioners should not be shoring up problems for the future by neglecting health improvement, as had been demonstrated in some sites where preventive services had been cut in the past due to financial circumstances. Moreover a

few interviewees saw some positive aspects: economic stringency was an opportunity for radical restructuring as well as a spur for prevention and 'investing to save'. Financial pressures might encourage whole system thinking:

'But I think the financial pressure might actually help us to think as a whole system, and that's certainly the position we're trying to get to here locally is how do we start changing the pathway and upstreaming services, so we can have the community focus on early intervention and our key partners are very much part of that. It's not easy obviously because everybody organisationally needs to keep their services well resourced but everyone recognises that's the change that we have to deliver.' (Director of Strategic Commissioning, Phase 2)

In the same way, the QIPP initiative could encourage a creative approach to partnership and to developing care pathways across health and social services, with the aims of avoiding duplication, improving efficiency and avoiding transfer problems across services. One site had carried out stakeholder events, including local authorities and the VCS, to explore the potential for joint working in the current economic climate.

The national survey also identified some positive views: for a small number of respondents, tightened budgets would mean an opportunity to tackle acute spend and plan disinvestment. Furthermore, a few respondents argued that a shift 'upstream' was gaining greater attention as a means of maximising return on investment.

9.4 Prioritising investment

As outlined in Chapter 4, WCC had promoted a public health-led approach to priority-setting, described by one interviewee as follows:

'And the criteria would be public health criteria in the main, ie the prevalence of the disease, the importance of the disease, in terms of burden ... the distribution of health needs by economic group, by ethnic group, by area, the cost-effectiveness of the existing treatments, the analysis of the existing service, and the gap between the existing service and the service you want, and so on and so forth.' (DPH, Phase 1)

In order to reach decisions on priorities, a combination of epidemiological, economic and modelling skills is required. Decisions can be informed by the following kinds of information.

- Epidemiological studies which estimate the burden of preventable disease. For example, the World Health Report ¹³¹ quantified more than 25 preventable risks to health and assessed cost-effective measures to reduce them.
- Estimates of costs linked to preventable illnesses or health damaging behaviours across health and other sectors.
- Scenario planning where health outcomes over specified time periods are modelled in relation to levels of investment. For example, 'scenario generator' ¹³² allows simulation of whole health and social care systems and is configured with data on prevalence and with a number of generic pathways of care.
- Predictive models showing the extent and direction of travel of major preventable health problems and associated costs.
- Discrete-event simulation models that allow different intervention scenarios to be costed.

- Programme budgeting and marginal analysis.
- Economic evaluation of evidence-based public health interventions.
- Identifying, measuring and tracking preventative health spend both as a measure of overall spend and within programmes of care.

The following section begins by summarising NICE's approach to assessing the cost-effectiveness of clinical interventions through its technology appraisal process, then analyses difficulties specific to the evaluation of public health interventions together with the potential candidate economic methods on offer. Although decisions over the balance of investment across total health spend raise additional issues to prioritising between interventions, the quality of predictive modelling and scenario generation partly rests on the evidence base in public health and economic evaluation of public health interventions. Subsequent sub-sections discuss preventative health spend and review a range of prioritisation tools.

9.4.1 Economic evaluation of public health interventions and 'return on investment'

One aspect of Wanless's fully engaged' scenario⁹ was the belief that public health programmes implemented effectively would preserve or improve population health while reducing long-term costs of health care treatment. He also argued that modelling and analysis of health and personal social services costs should be integrated and supported the role of NICE to assess the cost-effectiveness of health care interventions. However, there was no critical appraisal of its methods and no solutions offered for the further complexities generated when assessing public health interventions. In his update, Wanless¹⁰ identified the lack of funding for public health research; technical difficulties of generating evidence for public health; lack of depth and expertise in core disciplines; and the slow acceptance of economic perspectives within public health, as factors contributing to the lack of evidence for cost-effectiveness.

The NICE approach

NICE utilises a Cost/QALY (Cost per Quality- Adjusted-Life-Year) analytic framework to facilitate consistent funding decisions across different technologies and disease areas. Since there is seldom evidence that one clinical strategy dominates the alternatives (i.e. it is both more effective and less costly), the approach to synthesising evidence used by NICE generally rests on the estimating an incremental cost-effectiveness ratio (ICER) for the introduction of a new technology, with best guess estimates of ICERs between £20,000/QALY and £30,000/QALY. However, there are difficulties in applying this method to public health. In a briefing document on public health economic evaluation, Kelly et al.¹³³ acknowledged that 'the economic appraisal of public health interventions is both underdeveloped and intrinsically difficult' and had focused on downstream interventions. Upstream interventions which improve the circumstances in which people live may have a range of beneficial outcomes but only register weakly in specific public health targets such as smoking. Thus they may be hard to evaluate and justify as value for money.

Moreover interventions are often complex and may have public (non-exclusive) as well as individual benefits. Behavioral changes observed in public health interventions normally need to be modelled to estimate their long-term benefits making them necessarily tentative: an example is the uncertain relationship between one-month self reported smoking cessation rates and long-term changes in the incidence and costs of lung cancer. The time scales involved make it inevitable that process outcomes must be used as proxies for health outcomes but the attribution of genuine health gains becomes more circumspect.

Public health interventions also tend to be multi-faceted which means it is difficult or impossible to determine which facets of an intervention are causing change. These interventions may interact to a greater or lesser extent with their social context and setting and the synergies may be influential or essential in achieving change. Evaluation to assess the importance of discrete interventions (such as the randomised controlled trial (RCT)) may not provide generalisable or meaningful results. Cost-effectiveness analysis, designed to evaluate health outcomes utilising the narrow variances of clinical experiments with high internal validity but limited generalisability, is not well suited to address the large variances and cross-sectoral outcomes from public health interventions.

As mentioned above, the common outcome measure used by NICE is the quality-adjusted life-year (QALY), and this has been used to evaluate more clinically oriented public health interventions, such as smoking cessation services. Although public health interventions often appear to compare well against clinical interventions using a cost/QALY metric it is unclear whether this is just an artifact of the greater modelling assumptions necessary to assess public health interventions. Public health interventions also push an assumption inherent in the NICE cost/QALY approach to the limit, a QALY is a QALY no matter to whom it accrues. Three months improvement in quality-of-life from 0 to 0.1 is worth the same as from 0.9 to 1.0. Similarly three months additional survival is worth the same (bar the effect of time preference) whether it occurs now or in five years time. These values do not appear to resonate with society which seems to value rescuing those at the end-of-life far above the simple QALY estimate. Public health models forecast benefits which are often many years removed from intervention and thus the 'one QALY fits all' assumption seems questionable.

Options for the economic evaluation of public health

Whatever system of economic analysis is adopted should provide an unambiguous use of evidence and provide a decision rule that can be applied consistently across the field of public health. The three contenders currently offered are cost-effectiveness analysis (CEA using health gain as the outcome, traditionally referred to as cost-utility analysis or CUA), cost-benefit analysis (CBA) where costs and benefits are valued in monetary terms and cost-consequence analysis (CCA), which is not theoretically founded and allows for a profile of changes in costs and consequences within each sector.

If a generic well being measure was developed, it could be implemented in all public sectors together with a common public sector threshold and decision rule. Permitting different thresholds in different sectors would lead to more complex decision rules. Where monetary valuations of benefits are too difficult a CCA permits estimation of the costs accrued to different sectors as well as benefits described physically which can be assessed against the objectives of those sectors. Recognising the multi-attribute nature of outcomes no attempt is made to derive a summary cost-effectiveness ratio from the profile of costs and consequences, and it becomes a political and multi-sectoral decision whether investment is worth the returns. This framework may be most appropriate and informative in the context of discussions within commissioning partnerships. The extent of inter-sectoral agreement required for implementation would depend upon the rights and responsibilities of each sector represented.

NICE recognises a cost-consequence approach may be necessary to allow for the multi-attribute nature of public health interventions: public health guidance can consider non-health and intangible outcomes (such as the benefits of information) as well as issues of equity and distribution. Thus it is not clear that there is an unambiguous decision rule for public health, and pragmatism may be used to some extent to manage each intervention on a case-by-case basis.

How good is the evidence for public health interventions?

An extensive review of economic evaluations of public health interventions^{134,135} also reviewing previous attempts at this topic^{136, 137} showed that studies seldom considered non-health sector costs and consequences. There was a tendency towards shorter term or process outcomes rather than longer term generic health outcomes. Equity considerations were seldom considered and not addressed formally. The review of methodology identified a number of challenges including:

- The need for a debate about the theoretical and societal basis of current forms of economic evaluation. In common with others they recommend that the inter-sectoral impact of interventions should be quantified using cost-consequences analysis. Thus the scale and practicality of inter-sectoral compensation could be tested.
- Further research into a generic measure of well being that could be applied across public sector interventions. Additionally sector-specific generic measures of outcome would allow the shadow price of the investment (the additional output per additional unit of resource) within the budgets of each sector to be determined.

Claxton and colleagues¹³⁸ discuss some of the issues that arise in trying to generalise health economic methods into public health, in a context of different sectors with differing objectives and constraints. They favour a compensation test for public health interventions with multiple outcomes and inter-sectoral effects. However, compensations leading to an optimal allocation between sectors can only be made when these shadow prices are well understood.

In summary, therefore, because of limitations in more theoretically grounded approaches, inter-sectoral CCA approaches are likely to be most helpful to decision-makers identifying and evaluating initiatives undertaken in their locality or assessing the generalisability of initiatives evaluated elsewhere. When assessing public health interventions, there are no clear theoretical grounds to suppose the attribution of outcomes from RCTs will exceed that of the best quasi-experimental designs - it is more a case of which biases are most critical to manage, when external validity becomes paramount. In fact, quasi-experimental designs may offer distinct methodological advantages when interventions are designed to target inequalities.

The extent of modelling assumptions is, by necessity, greater for public health evaluations which place greater reliance on intermediate outcomes. Additionally these benefits are often predicted to occur many years after intervention. It is becoming apparent that the public may not value QALYs equally regardless of to whom they occur. For these two reasons comparison of public health QALYs and medical QALYs may stretch the modeling assumptions beyond reason.

Views of the evidence base

Interviewees reflected concerns over the evidence base for public health interventions, particularly in light of the importance of presenting a business case for longer term investment for health and well being. Although there was a limited evidence base on the effectiveness of public health interventions, interviewees considered there was insufficient evidence on cost-effectiveness or on return on investment over the longer term. The public health evidence base was currently underdeveloped and the lack of clear relationships between inputs and outcomes made it difficult to gain Board approval for proposals. Interviewees commented on the difficulties of prioritising longer term benefits over immediate demands on resources and that economic arguments for public health investment needed research and development if public health was to compete against arguments for increased resources from health care providers:

'And so I think that the economic argument for the public health investment needs a lot more research and development and a lot more strengthening because it's stacked up against an economic argument that's compelling from the health care providers.' (NED, Phase 1)

There were also difficulties in demonstrating return on investment across different preventive initiatives:

'You know, should we put all of our money and spend £5m and get people to go to Weight Watchers and lose weight or should we spend £5m on people giving up smoking or a combination of what?' (DPH, Phase 1)

The view was also expressed that far greater sums were being invested in areas of acute care where the evidence base was also weak. The emphasis on the public health evidence base was disproportionate with different rules being applied. The requirement to implement NICE guidance had the effect of promoting a drift towards specialised services.

Despite these concerns, differences emerged across sites in approaches adopted towards longer term investment for health gain. In two sites there was confidence that return on investment could be demonstrated:

'There's an evidence base for what works but there's not always an evidence base to show what the return on the investment is. ...That's what I mean about challenging public health to not sit back and go 'you've got to ring fence funds for us because we're the Cinderella here'... If you don't want to be slashed, prove you don't want to be slashed, do the return on investment work, and when you do it, you can prove there's a business case in there.' (DS, Phase 2)

Interviewees commented on the skills required for prioritising investment and for disinvestment. In particular, economic evaluation and economic modelling could inform decision-making and estimate return on investment. In one site, health economic modelling had provided a useful resource demonstrating the benefits of intervening in the prevention and primary care element of the care pathway and providing 'ammunition' for prioritising public health services. It was argued that public health had recently developed 'more of a public health economic outlook' - a focus described as lacking in the past. However, it was recognised that many of the required skills were lacking in PCTs and tools for modelling health impact needed further development:

'But the economic analysis has been not sophisticated in any sense at all, and it's one area where we feel, I think, and I don't think we're alone in this, we feel quite vulnerable in terms of our capacity to do that kind of analysis.' (DPH, Phase 1)

The economic crisis was also described as provoking a radical approach to overall spend where the emphasis would be on prevention to save costs and on assessing the effectiveness of all spend, rather than the 'two per cent on the margin'. However, in focusing on prioritisation of investment within a PCT there was a danger of missing possibilities for partnership working on the health and well being agenda. In recognition of this, joint modelling with local authorities was also being developed.

9.4.2 Preventative health spend

There are difficulties in establishing the resources allocated to preventive services within the NHS. In *Our Health Our Care Our Say*⁶ it was noted that:

'At present, the definition and measurement of spend on prevention are not easy to apply. Spend on prevention and spend on public health should be separated more clearly. International and UK definitions of preventative and public health spend are not aligned, and issues like service quality are not adequately captured'. (para. 6.34)

Under the aegis of the national reference group for health and well being 'Health England', an expert advisory panel on PHS reported on 'definitions and measures of preventative health spending' in the context of developing 'a 10-year ambition for preventative spending, based on a comparison with other OECD countries' (Further information available at: <http://www.healthengland.org/>). A preliminary report¹³⁹ identified resources currently directed at both preventive services and public health within PCTs, with a view to being able to assess commitments to spending

on prevention. It shows, for example, that there was wide variation in PCT spend on the Healthy Individuals Programme Budget category (2005/6) as a percentage of the total PCT allocation. The report distinguished between 'preventative interventions' and the narrower 'preventative health spending' which was limited by what could be reliably measured, costed and used for comparative purposes, both nationally and internationally. This included primary and secondary prevention, health promotion, family planning, school health services, national screening programmes, public health programmes for communicable and non communicable diseases and public health administration. The panel argued that, for comparison across PCTs, an enhancement of the national Programme Budget system should be developed and that for PCT comparison, spend on prevention as a percentage of total health spend should be used. Importantly, they argue that the spend in a country or locality should be related to levels of morbidity or mortality and that any new NSFs should include plans for monitoring spend and the effectiveness of preventative actions. However, difficulties remain over the breadth of the public health agenda and therefore what should be included and measured as part of public health spend.

Health England's key recommendations were that the OECD System of Health Accounts should be used for international comparisons of preventative health spend, and that programme budgeting should be developed to enable comparisons between PCTs. Health England's 2009 report¹²³ applied the OECD system to English data and found that total expenditure on prevention and public health services was £3.4bn in 2006/7 (£4.7bn if preventative expenditure on drugs was included). This amounts to around 3.5 per cent of total health care expenditure. However, the Audit Commission pointed out¹⁵ that centrally set contracts (such as for dental check ups and sight tests and payments under the QOF), centrally determined immunisation and vaccination programmes, and maternity and contraceptive services accounted for the bulk so that

'in fact, very little of the £3.7 billion was spent on direct public health interventions where there could be local flexibility. The largest sums were £159 million spent on the school health service and £172 million spent on lifestyle issues and smoking cessation services'.

The Health England 2007 report¹³⁹ recommended that spend should be expressed using a range of different units of analysis. These included cost-minimisation measures, cost-effectiveness measures and cost-utility measures. For cost-minimisation measures, total spend was the recommended unit of analysis. For cost-effectiveness measures, the rate of change in Years of Life Lost before 75 years was recommended. For cost-utility measures, the relevant units were Disability Adjusted Life Years (DALYs) or QALYs respectively.¹³⁹

Monitoring a shift in investment towards prevention requires identification of PHS as discussed above, although it was emphasised by PCT interviewees that PHS focused on measuring process rather than outcome. While programme budgeting and allocations through the primary care budget were indicative, PHS was often seen by interviewees as difficult, if not

impossible, to define and measure given the number of contexts in which preventive care was delivered. It was often categorised as growth money which had been allocated to addressing health inequalities or lifestyle interventions, or as spend which was under the control of the public health department or the health improvement team.

There were exceptions and two case study sites had focused on identifying and tracking health spend. One interviewee explained:

'I mean each year we can say that we're spending this extra money on prevention, but when we've done that baseline assessment, we went right down into well how much of the health visitors' time is about prevention, ... and we looked in quite some detail about all the different components that we could say was around health prevention ... what we'd like to do is revisit that and say well, using that same criteria, what does it look like now.' (FD, Phase 1)

In this site, the concept of PHS was clearly aligned to shifting the balance of spend towards prevention through the use of programme budgeting data:

'We've had this ambition for a few years now to increase spend on preventative health year on year by half a per cent. We also have a similar one which is to decrease our spend on the acute sector by one per cent year on year. So this is about actually putting into reality financially can you see the impact of improving health and reducing inequalities in our strategic finance plan as well as our strategic plan.' (Director of Strategy, Phase 2)

In a further case study site, specific recurrent investment in health and well being over a three year period had been agreed and this would be met through plans for disinvestment in the acute sector.

Although the limitations of the national 'Healthy Individuals' programme budgeting category in reflecting PHS were recognised, this category could be repackaged locally to include other areas of prevention such as QOF payments.

The national survey showed that around 55 per cent of PCTs said they were trying to calculate PHS, with programme budgeting being the most common method for achieving this. There was an even split between PCTs who said they tracked PHS (41 per cent) and those who did not (40 per cent). Forty five per cent of PCTs claimed they were using PHS as a strategy for increasing investment on health improvement and 35 per cent said they were not. Those who said they were using PHS explained they were doing it in a variety of ways. Several mentioned funding for targeted interventions for areas such as obesity, cardiovascular disease, diabetes and *Choosing Health* investments. Some noted the developmental status of PHS in their PCT.

9.4.3 Prioritisation tools

Commissioners want to ensure that each programme or intervention represents an efficient use of resources and that together these maximise total health benefits subject to budgetary and resource constraints. They are likely to have multiple objectives such as concern for the distribution of health benefits across the population (equity issues), representation of local user views, and balancing long and shorter term health gains. They therefore need different types of information, but decisions are also made

under uncertainty. Thus it is necessary to describe and quantify the uncertainty associated with decisions and the assumptions underlying them.

In England, there is currently no formal process for prioritising investment. While NICE provides evidence-based guidance including for public health interventions there is no overt process for ranking interventions. The choice of approach is influenced by whether the aim is to rank or prioritise within an overall budget for preventive services, shift the balance towards prevention across a pathway of care or increase the proportion of resources for preventive services across the system taken as a whole. These decisions are influenced by national priorities and the extent to which they are reflected in local priorities, the balance between clinical and non-clinical interventions and joint approaches across the NHS and partner agencies. Tools/support for prioritising can be broadly classified as follows.

- programme budgeting and marginal analysis (PBMA)
- tools to elicit preference for investment
- epidemiological modelling tools
- databases which include guides and costing tools.

These tools incorporate information on costs and/or benefits, or could be used to provide this information. They can be categorised by (i) their readiness for use to meet WCC competencies, (ii) the methods used, based on those identified within competencies six and eleven (e.g. predictive modelling), (iii) whether they can/do follow the care pathway, (iv) whether they can/do include user involvement, (v) whether they can/do include stakeholder/clinician involvement, (vi) equity issues, (vii) feasibility and user-friendliness. Most tools can be applied at different levels and all are subject to uncertainty. A more detailed account of prioritisation tools is included in Appendix five.

Prioritisation tools have different strengths and weaknesses. While inter-sectoral impacts, prevalence data and predictive modelling of costs and benefits over time are key criteria for considering shifting the gravity of spend towards prevention, these are not reflected in many of the most commonly used tools. Commissioners therefore need to consider biases built in to the choice of tools or the combination of tools which need to be considered in order to maximise health gain over time. The goals that commissioners identify prior to undertaking their assessments may help identify which tools are most relevant to them. Prioritisation tools may, to varying extents, focus on economic criteria, for example, whether or not health is maximised for the population served from the resources invested on the population's behalf. For other criteria, such as a concern for equity issues, some tools offer a more transparent approach than others.

The following sub-section summarises methods for prioritisation currently used in PCTs, views over their effectiveness (which are sometimes contradictory) and which approaches were considered most helpful.

9.4.4 Prioritisation in practice

Interviewees described a range of methods for prioritisation, mainly programme budgeting and PBMA, but other approaches included prioritising interventions across the life course; prioritising in relation to different scenarios (not limited to financial scenarios but also including changes in demography and patterns of health and illness); and prioritising across scenarios developed in conjunction with local authorities.

New proposals were often prioritised through locally developed approaches although these were often described as 'just a spreadsheet' and in the process of development. The process was similar across all case study sites: proposals were developed, scored against national targets, local targets and priorities in the commissioning and strategic plan, following which a business case was developed and the proposal further scrutinised and compared with other investments. Most PCTs used some kind of prioritisation matrix, gateway process or ethical framework to aid decision-making. Tools included varying numbers of criteria which might or might not include longer term benefits. Processes were being refined and weighted criteria applied to initiatives, often as a result of stakeholder involvement. Many interviewees noted that local tools had been developed for this purpose, but it was recognised that further work was needed. One PCT commissioner noted:

Ultimately we come down to what's the total cost being put forward in this particular bid, what number of people will it benefit and therefore what's the cost per beneficiary. What we haven't done is weight the level of benefit. Is it life saving? Is it a quality of life investment? And that, if you like, we haven't done that sort of weighting of the benefit really; it's quite crude, in other words. (DS, Phase 1)

This was borne out by the national survey which showed use of prioritisation matrices, health inequality intervention tools, NICE costing tools and programme budgeting, with only a handful of respondents stating their PCT did not use these. Around 25 per cent of PCTs responding to the survey appeared to have developed their own tools, with most mentioning their own modified prioritisation tools, whilst other individual PCTs noted that they are using: JSNAs as an 'evidence base', 'WCC processes', 'QALY/Value for Money for prevention', 'a commissioning toolkit', and tools designed to 'calculate the impact of preventive interventions'. One site had developed a 'clinical economic pathway process' which segmented care pathways, identified current spend, analysed evidence of effectiveness and determined the impact of further investment on the whole pathway.

A common approach was to use national programme budgeting data as a benchmarking tool in order to identify outlier areas, compared with the PCT cluster, as priorities for investigation and possible sources of savings. One interviewee described the process as follows:

'If you happen to be an outlier in terms of cost, but you're getting really good outcomes too, then actually that's not such a bad thing. But if you're an outlier in cost and your outcomes are worse than maybe your cluster group, who are getting better outcomes for less money, then what is it that they're doing that we're not?' (FD, Phase 2)

This process was useful where cost-effectiveness data were not available: investigating outliers could sharpen up the prioritisation process and could demonstrate areas where there could be a payback from preventive services and from primary care.

Programme budgeting was also described as being helpful in considering investing upstream within each programme, although the point was also made that questions should be also raised about the balance of resources across programmes as well as within them. However, it was difficult to compare costs of preventive services as there were so many different models in use across England.

As mentioned above, while the methodology was considered useful, the data were at least a year out of date and quality was variable as it depended on how trusts categorised spending. It was argued that the categories needed disaggregating if programme budgeting was to be a truly useful commissioning tool. For example, data were categorised by age which caused difficulties for joint planning and integration of children's services. One interviewee described it as follows:

'The local authority, they can't understand why we don't know what we spend on children's services. At one level we do but at one level we don't because obviously it's in every bit of our contracts. You have to cut it different ways, programme budgeting doesn't help us with that.' (Director of Strategic Commissioning, Phase 2)

There were also concerns raised amongst a number of interviewees that the way that programme budgeting was categorised nationally did not help locally in determining how resources were allocated across specific care pathways, for example, across prevention, primary and acute care for the cardiovascular care pathway. Some elements were 'hidden' in different programme areas. One interviewee commented:

'And so the only thing you can say about programme budgeting data is that it just kind of raises questions about the allocative efficiency, relative prioritisation of programme areas, but the data is so flawed that you couldn't make changes with a great deal of confidence based on that data. ... actually what you need is real live financial data, and you need to look at how your money's going out in real time, you can't use old data that's slightly flawed to make big investment decisions.' (Associate DPH, Phase 2)

The national survey showed that despite the seemingly widespread use of PB, there was limited support or understanding of it as a tool in decision-making for health. It was considered still in its infancy, it lacked accuracy and was a crude tool, failing to drill down sufficiently into different services. Some mentioned they had never had the time or opportunity to explore PB. For those who were supportive of PB, there were a small number of examples of it being used to identify under-funding in key areas of health and well being, but positive responses tended to be because it 'shows promise' and raised questions for further investigation.

A related area is PBMA. PCT interviewees demonstrated varying degrees of knowledge on this subject, as demonstrated below. One interviewee commented:

'It's been fantastic for us and it's the basis of our strategy, we've used it a lot.' (Director of Strategy, Phase 2)

Another commented that PBMA was useful in looking at resource allocation in relation to outcomes across a care pathway and the balance to be achieved. Some were beginning to use the tool and its importance in the context of WCC was recognised. Stakeholders, including practice-based commissioners, described how the cost-effectiveness of each initiative was assessed in relation to the effect on morbidity and mortality, possibly segmented by different groups and including some consultation with the community. However, there were others who considered that PBMA was difficult to implement:

'No, no one uses programme budgeting and marginal analysis and they should do ...we all know the theory, doing it is difficult... where (are) the 50 people that have got really good experience of putting it into practice locally that could come along... and show you how to do this, and we're going to use practical methods and routine data and we'll make a difference for you.' (DPH, Phase 2)

9.4.5 9.4.5 No easy answers

In general, technical issues of measurement or choice of criteria were discussed rather than underpinning values and ethical issues. Some interviewees expressed scepticism about the process as a whole: skills for using prioritisation tools were in short supply; weighting within prioritisation tools was difficult to agree (but could for example, reflect national targets or the size of population affected); and there was a lack of transparency and systematic rigour in the prioritisation process:

'So I think having tried to create a rational and straightforward and transparent process, when it actually came down to it, it was largely the kind of gut feelings of four executive directors late on a Friday afternoon about what was a good thing to do and what was not a good thing to do.' (DPH, Phase 1)

One interviewee emphasised that the process could not be reduced to a technocratic exercise:

'We've all agreed there's no science to it. There's no magical tool that's going to give you the answer You know, there are a range of factors that you're going to have to take into account from needs and the financial situation and the political situation and where the public is coming from. ...It's health inequalities, impact assessment, equality impact assessment, working with the local authority, looking at a sort of integrated impact assessment tool, where you take all these parameters in.' (DPH, Phase 2)

The variety of local approaches being adopted by PCTs was puzzling to some, especially given the wealth of research on prioritisation and the fact that all PCTs were trying to address similar issues. One interviewee noted:

'I find (it) ... bizarre that the NHS isn't signed up to a set of, isn't explicitly signed up to a set of ethical commissioning principles.' (Associate DPH, Phase 2)

There were examples of PCTs liaising over how to develop ethical frameworks in order to be able to score proposals and to provide transparency in decision-making. Many commented on difficulties in reaching agreement over prioritisation and, in practice, there was little time for PCTs to consider ethical issues around prioritisation in any depth.

This chapter demonstrates that prioritisation processes in PCTs are complex and linked to strategic development and organisational values as well as the

use of specific tools. Tools for prioritising health and well being are poorly developed and the evidence base for prioritising health and well being was considered inadequate. A new evidence base will not be fit for purpose unless it addresses the methodological challenges of evaluating public health interventions, rather than attempting to 'force a fit' of inappropriate clinical trial methods. This needs to be taken account of by commissioners as they assess the evidence base for public health interventions and return on investment.

10 Conclusions and recommendations

This report explores the impact of governance structures and incentive arrangements on commissioning for health and well being. The study took place at a time of rapid change, as PCTs developed their role as commissioning organisations. It was completed just before a new coalition government signalled substantial changes to commissioning in the NHS, including the eventual abolition of PCTs. Although the commissioning context is changing, the study raises generic issues related to commissioning for health and well being and explores the complexity of governance of public health, which goes beyond the governance arrangements of any single organisation.

This chapter begins by highlighting the complexity of governance of public health and the links between governance and incentives. WCC has acted as an additional performance management framework for PCTs, contributing to a strategic approach to improving health outcomes, but partnership governance has been relatively neglected. This chapter illustrates how a public health model of commissioning has been reflected in commissioning practice through comparing case study sites and identifies commissioning paradoxes arising from analysis of the main themes.

10.1 *Governance of public health*

Interpretations of the term 'governance' are proliferating. Descriptions of arrangements that entities make for their functioning have been extended to include notions of 'good governance' and a range of models (such as corporate governance and system governance) in which different modes of governance – typically categorised as hierarchies, networks and markets - co-exist. For example, while there are elements of a market mode of governance in the NHS, commissioners, acting as agents, also operate within a framework of national standards and regulatory arrangements. Governance of public health raises questions over the extent to which such arrangements promote health and well being and how public health values inform not only the governance processes associated with each aspect of the commissioning cycle but also governance across a local health system. It also raises questions over the relative emphasis accorded to the governance of local partnerships and involvement of the public. These areas are associated with additional governance tensions arising from a combination of horizontal with organisational accountability in the former, a patchwork of participatory approaches in the latter, and the co-existence of each with accountability through local democracy.

Governance structures and incentive arrangements are closely linked: not only do modes of governance influence the choice of incentives but governance arrangements can also act as incentives (or disincentives) in their own right. For example, performance management systems form part of governance arrangements for PCTs but can also act as incentives for

improved performance. On the other hand, the emphasis in governance arrangements on single organisational success can act as a disincentive for partnership working. While incentive arrangements can refer to commissioners' use of specific incentives to promote the delivery of preventive services, this occurs within the context of a health care system layered with incentives which may conflict with each other and which foster increased health care activity rather than longer term health gain.

Governance structures are intended to promote effective decision-making in line with the values and purpose of an organisation. However, performance management regimes which influence governance arrangements and commissioning practice within PCTs do not prioritise health and well being, given a hierarchy of targets in practice, and a focus on easily quantifiable, process-related targets. The introduction of WCC at the end of 2007 created an additional performance management framework which combined an outcomes-based approach with a systematic process, underpinned by commissioning competencies. This was considered to have promoted an emphasis on achieving improved health outcomes for the local population. WCC also led to changes in PCT organisational and governance structures so that they were better aligned with commissioning responsibilities. However, there was a potential lack of integration across the outcomes-based WCC assurance framework and other performance management approaches.

Governance within organisations forms only part of the picture for governance of public health, which involves working through partnerships and with local populations. Partnership governance was considered less well developed than intra-organisational governance. Most of the DsPH in the study were jointly appointed across the PCT and the local authority, but typically continued to work within, and remained accountable to the local PCT. The breadth of the health and well being agenda created further governance tensions: themed sub-groups of LSPs tended to fragment the health and well being agenda, with health often seen as the province of the PCT. This fragmentation was reflected in Health Scrutiny committees which often focused on health care rather than on partnership arrangements or on threats to health over the longer term, although there were some exceptions.

Given this degree of complexity it is not surprising that leadership, Board values and support of senior executives were considered the most important enablers to commissioning for health and well being for PCTs. The extent to which governance arrangements promoted health and well being was influenced by the extent to which decision-making was underpinned by public health values, and interpretations of the PCT's role in stewardship of the health of the local population. For example, where a stewardship role was narrowly defined, then public health priorities might not be adequately reflected in decision-making processes; where the focus was on governance arrangements within the NHS then the wider concept of stewardship across the wider health system could be lost.

10.2 *Commissioning for health and well being in case study sites*

A commitment to health and well being is reflected in the extent to which commissioning is public health-led, and indicated in the deployment of incentives for preventive services, the use of contractual flexibilities, attempts to shift the balance of investment through identifying and tracking preventative health spend and in the ways in which prioritisation tools are used for decision-making. It is also reflected in the involvement of public health teams with PBC and the success of partnership working. Analysis by case study site demonstrated many similarities across sites. There was a recognition of the contribution of WCC to an increased focus on health outcomes; the importance of partnerships for the longer term health and well being agenda; and the importance of Board values and leadership. However, most commissioners cited problems with the content and alignment of existing performance management structures; difficulties in performance management of primary care; and the complexities of governance of PBC given potential conflicts of interest in combining provider and commissioner roles. The historic importance of growth funds for the health and well being agenda and the consequent challenges of financial stringency were increasingly apparent as the study progressed. The majority of PCT interviewees were sceptical about maintaining a preventive focus in an economic downturn, but some were confident that return on investment for preventive services could be demonstrated.

Despite examples of commitment to the health and well being agenda at an individual or practice level, practice-based commissioners were largely concerned with demand management and pathway redesign, and there was little evidence of involvement in the health and well being agenda. Few were involved in the JSNA or local partnerships, for example, and integration with WCC competencies and processes was patchy.

However, case study sites differed both in the emphasis accorded to individual aspects of commissioning for health and well being and in the extent to which different activities were clustered. For example, there were differences in the extent to which LESs were exploited to incentivise preventive activity, address inequalities or encourage public involvement. While interviewees often described a public-health led approach to commissioning, this could be gauged through the extent to which public health was embedded in each aspect of the commissioning cycle; the success of partnership working and joint funding in relation to a health and well being agenda; the involvement of public health teams in PBC; or the development of a locality-based approach with community involvement. It was also evident in the extent to which longer term health gain was seen as an investment priority and associated with identifying and monitoring preventative health spend. There were differences in the extent of public involvement at Board level, in PBC and in the decision-making activities of commissioners as well as in VCS or community involvement in the JSNA.

There were sites which reflected most of these attributes and all included some. For example, one site showed extensive partnership working, a

locality approach and the use of numerous LESs for preventive services; another had used innovative methods for shifting investment and five sites were developing locality commissioning. Some differences between sites were contextual or depended on local leadership: reorganisations and changes in personnel could set back partnership working, as could lack of co-terminosity. In other cases, the preventive agenda had suffered when PCTs were in financial difficulties.

10.3 *Commissioning paradoxes*

The study illustrates a number of paradoxes in commissioning for health and well being related to: (i) the use of incentives in the NHS; (ii) public involvement in commissioning; (iii) the use of prioritisation tools; and (iv) the impact on commissioning practice of underlying values. These are briefly discussed in turn.

(i) Incentives for prevention services were optional and specific incentives were implemented in a context of system-wide incentives such as PbR, which were considered to promote activity rather than a longer term preventive agenda. There were few incentives for partnership working reflecting the emphasis on single organisational success.

There had been an overall increase in the use of LESs as the main route for incentivising health and well being services in primary care. Although effective, these were also described as fragmented and piecemeal. As optional services, they were vulnerable in times of economic downturn and had the potential to increase inequalities. Some rewards or incentives which fell outside contracts, such as additional resources associated with Spearhead status or Freed up Resources, seemed to have had little effect on commissioning health and well being services. Redefining core contracts, bundling targets into contracts across practices or devising local budgets which would incentivise outcomes rather than activity were all being discussed as ways forward. The use of incentives by commissioners was often carried out through trial and error and without reference to economic theories related to 'nudge' economics or optimal incentive contracts.

(ii) Greater involvement of the public in commissioning could reduce the emphasis on health and well being as public concern was largely focused on health care.

Public accountability is a key principle of governance. While there were many routes for engaging with the public, the use of LINKs by PCTs was variable, and there were different expectations from engagement by the PCT and by the VCS. Local involvement in commissioning for health and well being, whether at PBC or PCT level, was minimal, with little influence on decision-making. With some notable exceptions, the contribution of LINKs was under-exploited by PCTs. A further tension was the potential difficulty of achieving a balance across local responsiveness and the economies of scale required for effective commissioning.

(iii) An assessment of the relevance of prioritisation tools for meeting commissioning competencies related to prioritising investment, efficiency and effectiveness suggests that further assessment of their applicability for investing in longer term health gain is needed. Skills in using tools for prioritisation were generally poorly developed, as were methods for tracking and shifting the gravity of spend.

(iv) Commissioning for health and well being was often viewed as spanning the spectrum from prevention to acute care, with prevention seen as an 'earned agenda' dependent on release of funds from the acute sector.

WCC was still developing at the time of the study and was largely welcomed as providing an integrated and systematic approach focused on health outcomes. However, there was potential to focus on some aspects of the commissioning cycle at the expense of others, as reflected in the emphasis of PBC on demand management. Both the national survey and the case study data showed that most PCT interviewees were sceptical about maintaining a focus on commissioning for preventive service and investment for longer term health and well being in the context of an economic downturn.

These paradoxes will need to be addressed if commissioners are to fully address the health and well being agenda.

10.4 *Recommendations*

There are nine key recommendations followed by more detailed recommendations which flow from them.

1. Commissioning organisations should ensure that the underlying principle of stewardship of the health of the population informs governance structures and decision-making processes and is integrated into each aspect of the commissioning cycle. Our evidence shows variation in commissioning practice in relation to health and well being across almost every topic area studied.
2. Governance structures are associated with different approaches to incentives. They also influence decision-making and priority-setting. Governance structures can therefore be considered as an area for separate assessment and our evidence suggests that governance arrangements locally should be assessed by commissioning organisations for their potential to promote effective decision-making in relation to health and well being.
3. More attention should be directed by commissioners, working in partnership, to developing governance arrangements across a local public health system. Our evidence shows that governance processes within organisations predominate, despite new and more joined up regulatory arrangements which assess partnership in relation to outcomes across a local area. Arrangements for partnership governance could be assessed locally and more attention paid to monitoring of joint public health initiatives by PCTs, LSPs and SHAs.

4. PBC was largely focused on demand management with limited involvement in the JSNA, health and well being partnerships or assurance for WCC. PBC will require further development if it is to reflect all aspects of the commissioning cycle. This could build on ways in which public health teams and PBC consortia have worked together.
5. The use of financial incentives for preventive services through LESs is widespread in PCTs but they are optional, piecemeal, and could increase health inequalities. A more strategic approach to the use of incentives should build on evidence of pitfalls and potential areas of benefit, principles for optimal incentive contracts and developments such as 'nudge economics'. They should also take account of the interplay of incentives across a health care system.
6. Further research is needed on the use of prioritisation tools and their applicability for prioritising investment in health and well being over the longer term and across all spend, as opposed to between specific interventions or within a specific programme. This should include an analysis of the skills and capacity required to apply prioritisation tools and a clear indication of which aspects should be carried out at local, regional or national levels and any ethical questions which arise.
7. VCS involvement in commissioning strategies should be developed by local commissioners and ways of increasing public involvement in a preventive agenda explored. PCTs, PBC and local authorities should clarify the role LINKs are to play in influencing commissioning decisions.
8. There is increasing emphasis on developing the business case for prevention and public health interventions. Further research is needed on cost-effectiveness over the longer term in order to strengthen the rationale for public health investment. Commissioners will need to take account of the methodological challenges inherent in evaluating public health evaluations as they assess the evidence base for public health interventions and return on investment.
9. In each of the topic areas studied, we found examples of innovative practice. We also found PCTs working independently on key topics, such as criteria for prioritisation, which would benefit from collaboration. We therefore suggest that methods for knowledge exchange in relation to the preventive agenda are given more priority by policy makers and researchers and that knowledge exchange spans the range of organisations involved in the health and well being agenda.

Detailed recommendations:

10. Commissioning organisations should clarify the 'commissioning balance' across the immediate demands of health care and a longer term agenda for health and well being and make explicit the trade offs required.

11. A preventive agenda is enabled through a public health-led model of commissioning reflected in organisational arrangements, care pathway redesign, prioritisation processes and practice-based commissioning. Our case studies included examples where public health values were embedded in the commissioning process and others where public health teams played an advisory or advocacy role. The role and impact of public health teams on commissioning decisions could benefit from further research.
12. Preventive aspects of pathway redesign required development in collaboration with social services and others. This was highlighted by a number of interviewees and there were examples where this had already been developed. Good practice in cross-agency involvement in pathway redesign could be identified and disseminated.
13. More clarity is needed over how commissioners are to identify preventative health spend, given interviewee accounts of the anomalies in programme budgeting data.
14. Practice-based commissioning for the health and well being agenda was generally perceived to need further development. It is difficult for practices to achieve freed up resources through preventive services which means that effort is directed to demand management. Encouragement of collaborative approaches across practices may help to address this.
15. Our research showed that performance management regimes reflect a hierarchy of importance focused on selected national priorities and targets. A focus on longer term health gain would be encouraged through integrated approaches to performance management across SHAs and Government Offices and better integration of the outcomes- focused WCC with existing performance management regimes.
16. The effects of financial incentives included as part of baseline funding, such as Spearhead funding, were not monitored and their impact was unclear. This has implications for how action to improve health and address health inequalities is incentivised.
17. Further research is needed to link research on incentives with concerns of commissioners and the complex governance contexts in which they operate.
18. Overview and Scrutiny Committees for Health in our study often focused on health care issues, reflecting public concerns. Scrutiny committees could consider the balance to be achieved across scrutiny of health care issues, of health-related partnership working and action related to longer term investment for health.
19. Health and well being requires joint working and collaboration across a local public health system. Our evidence suggests that better integration across WCC outcomes and LAAs is required. Working in partnership, local agencies could carry out modelling and scenario

planning which is sensitive to changing population needs and resource constraints. More clarity is needed over the accountability arrangements of joint DsPH and the extent of their managerial responsibility in local authorities.

20. Commissioners working in partnerships could direct attention to the ways in which governance structures, such as those under the umbrella of the LSP, could be better integrated to address cross-cutting health and well being issues.
21. The JSNA is an important route for identifying health and well being needs of a local population. Our evidence shows that input of practice-based commissioners requires development as does data sharing, joint performance management of areas of shared interest and alignment of performance management frameworks for commissioning.
22. A systematic approach for involving the VCS in JSNAs was lacking in some of our case study sites and this may be an area for knowledge exchange across PCTs. We also found evidence of concern over conflicts of interest for PBC and the VCS in terms of health needs assessment, commissioning and the provision of services.
23. Performance management of primary care contracts was an area of common concern among PCTs and we recommend a review of developments, including the use of contractual levers, networked approaches and the changing balance between financial incentives and core contract specifications. This could reflect different perspectives on this issue, good practice locally and the advantages and disadvantages of transaction-based approaches.
24. Some PCTs were considering financial incentives for health outcomes (rather than for increased activity) through contracts based on collaborative arrangements or for care across care pathways. There is scope for comparative evaluation of new contractual arrangements of this kind.
25. PCTs, PBC and local authorities could consider the formal role to be played by LINKs in influencing commissioning decisions.
26. Leadership in public health requires negotiation of different forms and approaches to governance and an understanding of the tensions that arise. This could form part of leadership training.

The notion of 'public health governance' draws together issues arising in the governance of public health including how far a focus on health and well being is reflected throughout the commissioning cycle, in priorities for investment, performance management and the use of incentives and contractual arrangements. It is closely associated with the stewardship role, and as such, with values which should inform the wide range of governance arrangements that currently co-exist. As new governance arrangements take shape, it is important that the commissioning cycle is not fragmented

and that an emphasis on strategic commissioning for health and well being, based on joint assessments of health needs of a local population, is not lost.

11 References

1. Department of Health. *Commissioning a patient-led NHS* Cm 6268. London: Department of Health; 2005.
2. Department of Health. *World class commissioning: Vision*. London: Department of Health; 2007.
3. Department of Health. *World class commissioning: Competencies*. London: Department of Health; 2007.
4. Department of Health. *Commissioning assurance handbook*. London: Department of Health; 2008.
5. Department of Health. *World class commissioning assurance handbook Year 2*, London: Department of Health; 2009.
6. Department of Health. *Our health, our care, our say. A new direction for community services* Cm 6737. London: The Stationery Office; 2006.
7. Department of Health. *Commissioning framework for health and well being*. London: Department of Health; 2007.
8. Department of Health. *NHS 2010 – 2015: from good to great. Preventive, people-centred productive* Cm 7775. London: The Stationery Office; 2009.
9. Wanless D. *Securing our future health: taking a long-term view*. Final report. London: HM Treasury; 2002.
10. Wanless D. *Securing good health for the whole population*: Final report. London: HM Treasury; 2004.
11. Wanless D, Appleby J, Harrison T, Patel D. *Our future health secured? A review of NHS funding and performance*. London: King's Fund; 2007.
12. House of Commons Health Committee. *Health inequalities. Third Report of Session 2008–09, Vol I*. HC 296-1. London: The Stationery Office; 2009.
13. Healthcare Commission and Audit Commission. *Are we choosing health? The impact of policy on health improvement programmes and services*. London: Commission for Healthcare Audit and Inspection; 2008.
14. The Marmot Review. *Fair society, healthy lives: strategic review of health inequalities in England post-2010*. London: The Marmot Review; 2010.
15. Audit Commission. *Healthy balance. A review of public health performance and spending*. Health Briefing March 2010. London: Audit Commission; 2010.
16. Department of Health, Health Inequalities Unit. *Tackling health inequalities 2005-7. Policy and data update for the 2010 national target*. London: Department of Health; 2008.

17. Department of Health. *Tackling health inequalities: a programme for action* Cm 6374. London: Department of Health; 2003.
18. Department of Health. *Transforming community services: enabling new patterns of provision*. London: Department of Health; 2009.
19. Secretary of State for Health. *High quality care for all: NHS next stage review final report* Cm 7432. London: The Stationery Office; 2008.
20. Audit Commission, Care Quality Commission, HM Inspectorate of Constabulary, HM Inspectorate of Prisons, HM Inspectorate of Probation and Ofsted. *Comprehensive area assessment framework document*. London: Audit Commission; 2009.
21. DH/NHS Finance Performance and Operations. Operational Plans 2008/09 - 2010/11. *National planning guidance and "Vital Signs"*. London: Department of Health; 2008.
22. Department of Health/NHS Finance Performance and Operations. *The operating framework for 2010/11 for the NHS in England*. London: Department of Health; 2009.
23. Department of Health. *Implementing the Next Stage Review visions: the quality and productivity challenge*. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_104239
24. Crump H. World Class Commissioning Table: PCTs exceed expectations in year one. *Health Service Journal*, 5 March 2009. Available at: <http://www.hsj.co.uk/pcts-exceed-expectations-in-year-one/2001726.article>
25. Department of Health. *Equity and excellence: liberating the NHS* Cm 7881. London: The Stationery Office; 2010.
26. Davies C, Anand P, Artigas L, Holloway J, McConway K, Newman J et al. *Links between governance, incentives and outcomes: a review of the literature*. London: National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO); 2005.
27. Marks L, Cave S, Hunter DJ. Public health governance: views of key stakeholders. *Public Health* 2010; 124: 55-59.
28. Department of Health. *National standards, local action. Health and social care standards and planning framework 2005/06 – 2007/8*. London: Department of Health; 2004.
29. NHS National Leadership Council. *The healthy NHS board. Principles for good governance* 2010. Available at: http://nhsleadership.rroom.net/boarddevelopment/docs/bd_principles_document_11.pdf
30. The Mid-Staffordshire NHS Foundation Trust Inquiry. *Robert Francis Inquiry report into Mid-Staffordshire NHS Foundation Trust*. London: The Stationery Office; 2010.

31. The World Wide Indicators Governance Project. Available at:
<http://info.worldbank.org/governance/wgi/index.asp>
32. Independent Commission on Good Governance in Public Services. *The good governance standard for public services*. London: Office for Public Management, Chartered Institute of Public Finance and Accountability; 2004.
33. Audit Commission. *Corporate governance: improvement and trust in local public services*. London: Audit Commission; 2003.
34. Gash T, Hallsworth M, Ismail S, Paun A. *Performance Art: enabling better management in the public services*. London: Institute for Government; 2008.
35. Blackman T, Elliott E, Greene A, Harrington B, Hunter DJ, Marks L et al. (2006) Performance assessment and wicked problems: the case of health inequalities, *Public Policy and Administration* 2006; 21(2): 66-80.
36. Butland B, Jebb S, Kopelman P, McPherson K, Thomas S, Mardell J et al. *Tackling obesities: future choices*. Project report. Government Office for Science. London: Department of Innovation Universities and Skills; 2007.
37. Courpasson D. Managerial strategies of domination: power in soft bureaucracies. *Organization Studies* 2000; 21(1): 141-61.
38. Flynn R. 'Soft bureaucracy', governmentality and clinical governance; theoretical approaches to emergent policy. In Gray A, Harrison S. (eds.) *Governing medicine. theory and practice*. Open University Press: 2004. pp. 11-27.
39. Treib O, Bahr H, Falkner G. *Modes of governance: a note towards conceptual clarification*. European Governance Papers (EUROGOV) No N-05-02: 2005. Available at: <http://www.connex-network.org/eurogov/pdf/egp-newgov-N-05-02.pdf>
40. Exworthy M, Powell M, Kohan J. The NHS: quasi-market, quasi-hierarchy and quasi-network? *Public Money and Management* 1999; 19(4):15-22.
41. Greener I, Powell M. The changing governance of the NHS: Reform in post-Keynsian health service. *Human Relations* 2008; 61: 617- 635.
42. Hooghe L, Marks G. *Types of multi-level governance*. European Integration on-line Papers 2001; 5 (11). Available at:
<http://eiop.or.at/eiop/texte/2001-011a.htm>
43. Townsend A. *Multi-level governance, with particular reference to integration between levels*. ODPM; 2005. Available at:
<http://www.communities.gov.uk/documents/corporate/pdf/146784.pdf>
44. Secretary of State for Communities and Local Government. *Strong and prosperous communities. The Local Government White Paper Cm 6939-II*. London: The Stationery Office; 2006.

45. Audit Commission. *A prescription for partnership. Engaging clinicians in financial management*. London: The Audit Commission; 2007.
46. Bullivant J, Deighan M, Stoten, B, Corbett-Nolan A. *Integrated governance II: Governance between organisations*. Institute of Healthcare Management and Bradford and Airedale Teaching Primary Care Trust. 2008
Available at:
<http://www.wales.nhs.uk/sitesplus/documents/829/Integrated%20Governance%20II%20%20Governance%20Between%20Organisations%20Bullivant%20et%20al.pdf>
47. Tuohy AH. Agency, contract, and governance: shifting shapes of accountability in the health care arena, *Journal of Health Policy, Politics and Law* 2003; 28 (2-3): 195-215.
48. Barnes M, Skelcher C, Beirens H, Dalziel R, Jeffares S, Wilson L. *Designing citizen centred governance*. York: Joseph Rowntree Foundation; 2008.
49. Department of Health, Patient and Public Involvement Team. *A stronger local voice: A framework for creating a stronger local voice in the development of health and social care services*. London: Department of Health; 2006.
50. Secretary of State for Communities and Local Government. *Communities in control: real people, real power* Cm 7427. London: The Stationery Office; 2008.
51. Department of Health, Commissioning and System Management. *Real involvement: working with people to improve services. Guidance for NHS organisations on section 242(1B) of the NHS Act 2006, the duty to involve and good involvement practice*. London: Department of Health; 2008.
52. Jochum V, Pratten B, Wilding K. *Civil renewal and active citizenship. A guide to the debate*. London: NCVO; 2005.
53. Department of Health. *Overview and scrutiny of health – Guidance*. Department of Health 2003. Available at:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4066238.pdf
54. Hunter DJ, Marks L. *Managing for health: what incentives exist for NHS managers to focus on wider health issues?* London: King's Fund; 2005.
55. World Health Organisation. *World Health Report 2000*. Geneva: World Health Organisation; 2000.
56. Bennett B, Gostin L, Magnusson R, and Martin R. Health governance: law, regulation and policy. *Public Health* 2009; 123: 207-12.
57. Nuffield Council on Bioethics. *Public health: ethical issues*. London: Nuffield Council on Bioethics; 2007.

58. Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health*, Geneva: World Health Organisation; 2008.
59. Hunter DJ, Marks L, Smith K. *The public health system in England*. Bristol: Policy Press; 2010.
60. Gostin LO. *Public health law: power, duty, restraint* (2nd ed.) University of California Press, Berkeley, Los Angeles: 2008.
61. Kass NE. Public health ethics; from foundations and frameworks to justice and global public health. *Journal of Law Medicine and Ethics* 2004; 32: 232-242.
62. Dawson A, Verweij M. The meaning of 'public' in 'public health' cpt. 2 in Dawson A, Verweij M. (eds.) *Ethics, prevention and public health*. Oxford: Oxford University Press; 2007. pp.13-29.
63. Peckham S, Hann A. (eds.) *Public health ethics and practice*. Bristol: Policy Press; 2009.
64. Holland S. Public health ethics; what it is and how to do it. In Peckham S, Hann A. (eds.) *Public health ethics and practice*. Bristol: Policy Press; 2009. pp.33-48.
65. Jochelson K. *Nanny or steward? The role of local government in public health*. London: King's Fund; 2005.
66. Gostin LO, Stone L. Health of the people: the highest law? In Dawson A, Verweij M. (eds.) *Ethics, prevention and public health*. Oxford: Oxford University Press; 2007. pp. 59-77.
67. Wikler D, Brock DW. Population bioethics. mapping a new agenda. In Dawson A, Verweij M. (eds.) *Ethics, prevention and public health*. Oxford: Oxford University Press; 2007. pp.78-94.
68. Cribb A. Why ethics? What kind of ethics for public health? In Peckham S, Hann A. (eds.) *Public health ethics and practice*. Bristol: Policy Press; 2009. pp.17- 31.
69. Department of Health. *PCT and SHA functions and roles 2006*. Available at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4134649
70. NHS Confederation. *The development of integrated governance*. NHS Confederation Viewpoint. London: NHS Confederation; 2004.
71. Scally G, Donaldson LJ. Looking forward: clinical governance and the drive for quality improvement in the new NHS in England. *BMJ* 1998; 317: 61–65.
72. Storey J, Bate P, Buchanan D, Green R, Salaman G, Winchester N. *New governance arrangements in the NHS: emergent implications*. NHS/SDO Working Paper No 3/2008. Available at:
http://www7.open.ac.uk/oubs/research/pdf/SDO_Project_08_3.pdf

73. Abbot S, Smith R, Proctor S, Iacovou N. Primary Care Trusts. What is the role of Boards? *Public Policy and Administration* 2008; 23: 43- 59.
74. Rhodes RAW. The new governance: governing without government. *Political Studies* 1996; xliv: 652-667.
75. Department of Health. *The new NHS: modern, dependable* Cm 3807. London: Department of Health; 1997.
76. Department of Health. *Healthy weight, healthy lives. A cross government strategy for England*. London: Department of Health; 2008.
77. Kelly M, Stewart E, Morgan A, Killoran A, Fischer A, Threlfall A et al. A conceptual framework for public health: NICE's emerging approach. *Public Health* 2009; 123 (1): e14-e20.
78. Health care Commission. *No ifs, no buts: Improving services for tobacco control*. London: Health care Commission; 2007.
79. Healthcare Commission. *Performing better: A focus on sexual health services in England*. London: Healthcare Commission; 2007.
80. Healthcare Commission. *Managing diabetes: Improving services for people with diabetes*. London: Healthcare Commission; 2007.
81. Institute for Government. *PSA Indicators*. Available at: <http://www.instituteforgovernment.org.uk/content/19/psa-indicators>
82. Department for Communities and Local Government. *The New Performance Framework for Local Authorities & Local Authority Partnerships: Single Set of National Indicators 2007*. Available at: <http://www.communities.gov.uk/documents/localgovernment/pdf/505713.pdf>
83. HM Treasury. *2007 Pre-Budget Report and Comprehensive Spending Review*. London: The Stationery Office; 2007.
84. Secretary of State for Health. *Choosing health: making healthy choices easier* Cm 6374. London: The Stationery Office; 2004.
85. Care Quality Commission. *Reviews in 2009/10. Assessing and rating health and adult social care organisations*. Available at: http://www.cqc.org.uk/_db/_documents/cqc_reviews_0910.pdf. Accessed March 2010.
86. Audit Commission. *Working better together? Managing local strategic partnerships*. London: Audit Commission; 2009.
87. HM Treasury and Department of Communities and Local Government. *Total Place: A whole area approach to public services*. London: HM Treasury; 2010.
88. Bernstein H, Cosford P, Williams A. *Enabling effective delivery of health and wellbeing. An independent report*. 2010. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111692

89. Marks L. Fault lines between policy and practice in local partnerships. *Journal of Health Organization and Management* 2007; 21(2): 136-148.
90. Johnson C, Osborne SP. Local Strategic Partnerships, neighbourhood renewal and the limits to co-governance. *Public Money and Management* 2003; July: 147-154.
91. Hunter DJ (ed.) *Perspectives on joint Director of Public Health appointments*. Durham: Durham University; 2008.
92. The Centre for Public Scrutiny. *Commissioning for health – a guide for overview and scrutiny committees on NHS commissioning and the world class commissioning programme 2010*. Available at: <http://www.cfps.org.uk/what-we-do/publications/cfps-health/?id=120>
93. Culyer AJ. *Dictionary of health economics*. Cheltenham: Edward Elgar Publishing Ltd.; 2005.
94. Le Grand J, Titmuss R, Srivastava D. *Incentives for prevention*. Health England Report No 3. 2009. Available at: <http://www.healthengland.org/publications/HealthEnglandReportNo3.pdf>
95. Mannion R, Davies HTO. Incentives in health systems; developing theory, investigating practice, *Journal of Health Organization and Management* 2008; 22 (1): 5-10.
96. Williamson OE. Markets and hierarchies: some elementary considerations. *American Economic Review* 1973; 63:316-25.
97. Le Grand J. *Motivation, agency, and public policy: of knights and knaves, pawns and queens*. Oxford: Oxford University Press; 2006.
98. Williamson OE. The theory of the firm as governance structure: from choice to contract. *Journal of Economic Perspectives* 2002; 16:171-95.
99. Marini G, Street A. A transaction costs analysis of changing contractual relations in the English NHS. *Health Policy* 2007; 83:17-26.
100. Thaler RH. *Quasi rational economics*. New York: Russell Sage Foundation; 1994.
101. Milgrom P, Roberts J. *Economics, organization and management*. Englewood Cliffs, N.J.: Prentice Hall; 1992.
102. NHS Employers. *QOF changes and new indicators for 2009/10*. London: NHS Employers; 2009.
103. Steel NMS, Clark A, Fleetcroft R, Howe A. Quality of clinical primary care and targeted incentive payments: an observational study. *British Journal of General Practice* 2007; 57: 449-454.
104. Hadley-Brown M. The QOF: quality outcomes or just framework?" *Diabetes and Primary Care* 2005; 7(2): 52-60.
105. Millett C. et al. Impact of a pay-for-performance incentive on support for smoking cessation and on smoking prevalence among people with diabetes. *Canadian Medical Association Journal* 2007; 176: 1705-10.

106. Doran T, Fullwood C, Kontopantelis E, Reeves D. Effect of financial incentives on inequalities in the delivery of primary clinical care in England: analysis of clinical activity indicators for the quality and outcomes framework. *Lancet* 2008; 372:728-36.
107. Sigfrid LA, Turner C, Crook D, Ray S. Using the UK primary care Quality and Outcomes Framework to audit health care equity: preliminary data on diabetes management. *Journal of Public Health* 2006; 28:221-5.
108. Campbell SM, Reeves D, Kontopantelis E, Sibbald B, Roland M. Effects of pay for performance on the quality of primary care in England. *New England Journal of Medicine* 2009; 361:368-78.
109. Petersen LA, Woodard LD, Urech T, Daw C, Sookanan S. Does pay-for-performance improve the quality of health care? *Annals of Internal Medicine* 2006; 145:265-72.
110. Pearson SD, Schneider EC, Kleinman KP, Coltin KL, Singer JA. *The impact of pay-for-performance on health care quality in Massachusetts, 2001-2003*. Health Aff (Millwood) 2008; 27:1167-76.
111. Information Centre for Health and Social Care. *Spend on new clinical DESs in England, 2008/09 and forecast for 2009/10*. Available at: http://www.ic.nhs.uk/webfiles/publications/TSC/Spend_on_New_Clinical_DESs_in_England_2008_09_and_forecast_for_2009_10.pdf
112. Audit Commission. *Payment by Results data assurance framework 2008/09: Key messages from Year 2 of the national clinical coding audit programme*. London: Audit Commission; 2009.
113. Farrar S, Sussex J, Yi D, Sutton M, Chalkley M, Scott A et al. *National evaluation of payment by results*. Aberdeen: University of Aberdeen; 2007.
114. Farrar S, Yi D, Sutton M, Chalkley M, Sussex J, Scott A. Has payment by results affected the way that English hospitals provide care? Difference-in-differences analysis. *BMJ* 2009; 339:b3047.
115. Department of Health. *Options for the future of payment by results: 2008/09 to 2010/11*. Leeds: Department of Health; 2007.
116. Wyatt S. Investing for Health Project 1. *The rationale and potential risks of introducing tariffs for lifestyle risk management services*. Reference Group 1 paper. Birmingham: NHS West Midlands; 2008.
117. Wyatt S. *Investing for Health Project 1. Tariff levels for smoking cessation services*. Reference Group Paper 3. Birmingham: NHS West Midlands; 2008.
118. Department of Health. *The NHS in England: the operating framework for 2009/10*. London: Department of Health; 2008.
119. Curry N, Goodwin N, Naylor C, Robertson R. *Practice-based commissioning. Reinvigorate, replace or abandon?* London: King's Fund; 2008.

120. Thaler RH. *Quasi rational economics*. New York: Russell Sage Foundation; 1994.
121. Thaler RH, Sunstein CR. *Nudge: improving decisions about health, wealth, and happiness*. New Haven and London: Yale University Press; 2008.
122. Draper P, Griffiths J, Dennis J, Popay J. *Three types of health education*. *BMJ* 1980; 281(6238): 493–495.
123. Health England (Expert Advisory Panel on Preventative Health Spending). *Prevention and preventative spending*. Oxford: Health England, 2009.
124. Leary S, Palmer M. A healthy option. *Healthcare Finance* 2009; 29: 31-2.
125. Kane RL, Johnson PE, Town RJ, Butler M. Economic incentives for preventive care. Evidence Report. *Technology Assessment* 2004:1-141.
126. Oliver A. Can financial incentives improve health equity?[comment]. *BMJ* 2009; 339:b3847.
127. Pearson SD, Lieber SR. Financial penalties for the unhealthy? Ethical guidelines for holding employees responsible for their health. *Health Aff (Millwood)* 2009; 28:845-52.
128. Newman J. *Modernising governance: New Labour policy and society*. London: Sage; 2001.
129. Improvement and Development Agency. *Valuing health: developing a business case for health improvement*. London: Improvement and Development Agency; 2009.
130. Austin D. *Priority-setting: strategic planning*. London: NHS Confederation; 2008.
131. World Health Organisation. *The World Health Report: reducing risks, promoting healthy life*. Geneva: World Health Organisation; 2002.
132. NHS Institute for Innovation and Improvement. *What is the scenario generator?* Available at: http://www.institute.nhs.uk/scenariogenerator/general/what_is_the_scenario_generator.html
133. Kelly MP, McDaid D, Ludbrook A, Powell J. *Economic appraisal of public health interventions*. London: National Institute for Health and Clinical Excellence; 2005.
134. Drummond M, Weatherly H, Claxton K, Cookson R, Ferguson B, Godfrey C, Rice N, Sculpher M, Sowden A. *Assessing the challenges of applying standard methods of economic evaluation*. York: Public Health Research Consortium; 2007.
135. Drummond M, Weatherly H, Ferguson B. Economic evaluation of health interventions. *BMJ* 2008; 337:a1204.

136. West P, Sanderson D, Redmond S, Taylor M, Duffy S. *A critique of the application of cost-effectiveness analysis to public health*. York: York Health Economics Consortium; 2003.
137. McDaid D, Needle J. *Economic evaluation and public health: Mapping the literature*. Cardiff: Health Promotion Division, Welsh Assembly Government; 2006.
138. Claxton K, Sculpher M, Culyer T. *Mark versus Luke? Appropriate methods for the evaluation of public health interventions*. CHE research paper 31. York: Centre for Health Economics, University of York; 2007.
139. Health England (Expert Advisory Panel on Preventative Health Spending). *Definitions and measures of preventative health spending*. Report no 1 Oxford: Health England; 2007.

Appendix 1 Focus group guide

Public health governance and primary care delivery

Regional focus group

Purpose of focus group

- To scope dimensions of 'public health governance'
- To inform development of the research project, 'Public Health Governance and Primary Care Delivery', funded as part of the NIHR Service Delivery and Organisation public health research programme

Focus group objectives

- To explore dimensions of governance of relevance to population health (public health governance)
- To identify similarities and differences with other forms of governance, such as clinical governance
- To identify changes associated with implementing systems for public health governance at SHA and local levels
- Current barriers to commissioning for health and well being
- Levers for more effective commissioning for health and well being.

Appendix 2 Interview schedules: examples from phase one and phase two

First phase interview schedules were informed by the following: mapping and scoping exercises carried out as part of the exploratory phase of the study; the findings of one national and two regional focus groups; and interviews (four) with national stakeholders. The mapping exercise (SC) clarified the configuration of incentives and regulatory arrangements for health improvement and the reduction of health inequalities; the scoping exercise identified dimensions of governance related to health improvement; the focus groups debated dimensions of governance and governance challenges; the four additional interviews with national stakeholders followed the themes of the focus groups. Draft interview schedules were piloted with two interviewees (a member of the project advisory group and a national stakeholder from the VCS and modified accordingly. There was a wide range of interviewees, spanning PCT Chief Executives and Executive Directors, PCT Chairs and NEDs, PBC leads, members of the VCS with a role in the health sub-group of the LSP, the Chair of the Overview and Scrutiny Panel for Health and the Chair of the LINK. Interview schedules were modified to reflect differences in roles. The schedules were also modified for the second phase interviews which took place late in 2009, to reflect changes in policy and also to follow up on themes identified in the first phase of interviews. Interviews took one hour to complete.

Two schedules are reproduced below, one for PCT interviewees (phase one) and a second for practice-based commissioners (phase two).

1. Interview schedule for phase one PCT interviewees

A. Background

A.1 First of all, could you describe your current role?

A.2 Could you describe how your PCT carries out its commissioning responsibilities?

- PCT with sole responsibility for commissioning?
- Commissioning arrangements across (which) PCTs?
- External commissioners (which ones)?
- Joint commissioning arrangements and extent of joint commissioning for the health and well being agenda?

A.3 What is your current involvement in commissioning?

B. The second section looks at arrangements for commissioning health and well being and addressing health inequalities in more detail.

B.1 There has been a great deal of policy emphasis on commissioning for health and well being. How far has your organisation been able to reflect this emphasis in its commissioning priorities?

- Response to the Commissioning Framework for Health and Well Being?
 - Response to Vision for World Class Commissioning?
 - Examples of success?
- B.2** Is the emphasis on health and well being about right in your organisation?
- If not, what are the current barriers to achieving change in the balance of investment?
- Trade offs across short and longer term investment?
 - Clinical versus public health focus?
 - Current pattern of regulatory and incentive arrangements?
 - Skills and competencies?
 - Partnership issues?
 - Board priorities?
- B.3** What would you consider as the most effective levers for change in this area?
- B.4** To what extent is the commissioning process driven by public health priorities?
- Involvement of the public health team in the commissioning process and in deciding commissioning priorities?
 - The extent to which the Director of Public Health annual report is reflected in commissioning intentions?
- B.5** Are there barriers to public health teams exerting more influence?
- B.6** Are you able to comment on the extent to which strategies for health improvement, commissioning priorities and financial strategies are currently aligned with each other?
- If aligned, how has this been achieved?
 - If not, then what have been the barriers to achieving this?
- B.7** How are the public currently involved in commissioning decisions?
- Involvement in health and well being as opposed to health care?
 - Potential role of LINKs and how they will be integrated into PCT decision-making structures?
- B.8** How would you describe progress with the JSNA in your area?
- If in place, how is it being used to identify future service needs and inform commissioning decisions?
- B.9** In your view, to what extent are JSNAs likely to influence PCT commissioning intentions over time?
- Barriers?
 - Link with LAAs?
- B.10** What impact to you think the recent Darzi review will have on commissioning for health and wellbeing?
- B.11** Moving on to practice-based commissioning, how would you describe progress on PBC in your PCT?
- Supporting strategic goals of the PCT?
 - Involvement in setting commissioning intentions?

- Number of business plans?
 - Involvement in committees?
 - Influence on PCT decision-making?
- B.12** To what extent are practice-based commissioners currently involved in the health and well being agenda?
- Influence on the commissioning intentions in the AOP?
 - Involvement in the JSNA process?
 - Input into the development of LAAs?
 - Involvement in the implementation of LAAs?
 - Broader strategies and targets for health improvement?
 - Examples of local successes and how these have been achieved?
- B.13** What incentives are there, if any, for them to engage in commissioning for health and well being?
- Any support and incentives from the PCT?
 - Access to freed up resources/savings as a result of PBC activities?
- B.14** What, in your view could make them more likely to engage in commissioning health improvement services?
- B.15** What role could the PCT play in incentivising practice-based commissioners to commission health improvement services?
- B.16** Are there any general points on barriers and enabling factors to engaging PBC in this area that you would like to add?
- C.** The third section looks at performance management systems, regulatory arrangements and standards and their impact on commissioning for health and well being.
- C.1** To what extent do you think the current system of performance management for PCTs supports a shift in emphasis towards health and wellbeing in practice?
- Impact of Annual Health Check?
 - Impact of Vital Signs and the Annual Operating Framework?
 - Impact of the PSA targets?
 - Impact of target-setting through Local Area Agreements?
 - Role of the SHA in performance managing this area?
 - Commissioning assurance procedures?
 - Impact of NICE guidance?
 - Impact of NSFs?
- C.2.** In practice, which areas of performance management predominate for the PCT?
- C.3** Do you expect this to change over the next few years?
- C.4** In relation to the joint agenda with local authorities, has commissioning for health and well being raised any specific issues of governance in your PCT?
- Alignment of performance management across different organisations?

- Performance management in relation to the Government Office and the SHA?
 - Extent to which the LAA is included within the AOP?
 - Incentives to partnership working?
- C.5** Are there issues of governance related to health protection?
- C.6** What impact do you think the new regulatory arrangements will have on commissioning for health and well being?
- The impact of the Care Quality Commission on assessing commissioning arrangements for health and well being?
 - The new national indicator set
 - Comprehensive Area Assessment and the impact of joined-up regulation?
- D.** The fourth section looks in more detail at incentives for commissioning for health and well being.
- D.1** The *Commissioning Framework for Health and Well Being*, (DH 2007) noted that incentives did not yet 'fully support the delivery of better health and well being'. Do you agree with this?
- Impact of specific incentives?
 - Balance of incentives?
- D.2-5** (For Spearhead PCTs). We would like to identify the any impact Spearhead status may have had on commissioning decisions and health outcomes.
- D.2** How much extra funding have you received as a Spearhead PCT?
- D.3** How would you describe the impact of Spearhead status on commissioning for health and well being in your PCT?
- Documentation available?
- D.4** Have projects been mainstreamed?
- D.5** Is it possible to identify any impact on health outcomes?
- D.6** Has the PCT exploited its contractual flexibilities in order to commission services for health and well being?
- Contracts with provider services that incorporate tariffs for health improvement services
 - Local Enhanced Service element of GMS contract (details)
 - APMS or PMS contracts
 - Services from the VCS
 - Social enterprises
- D.7** It has been argued that the current pattern of incentives works against a longer term approach to health and well being. Do you agree with this view? If so, what changes in the nature or balance of incentives would you like to see?
- D.8** What would be the best ways, in your view, to incentivise the development of health and well being services?
- Through extension of PbR?
 - Extending choice to health promotion services?

- More involvement of the public in commissioning?
 - Closer working with partners?
- D. 9** Are financial incentives the most important lever for change?
Are other kinds of incentives important and if so, which ones?
- E.** The fifth section focuses on decision-making and investment for health.
- E.1** What is the process for agreeing priorities for investment in health and well being in your PCT?
- Specific priority-setting methods
 - Extent to which methods of economic evaluation are included?
- E.2** Is it possible to identify preventative health spend in your PCT?
If yes, how is this defined, what issues emerge, and is documentation available?
If no, are there plans to do this?
- E.3** What are your views over the feasibility of using preventative health spend as a measure?
- E.4** Is it possible to track how preventative spend is changing over time?
- E.5** Could you describe any plans to rebalance investment towards health improvement?
- Enabling factors?
 - Barriers?
- E.6** How useful is the programme budgeting initiative in this respect?
- E.7** Which methods are being used/is it planned to use?
- Modelling costs and investments over short medium and longer terms?
 - Looking across pathways of care?
 - PBMA?
 - Disinvestment strategies?
 - Changing pattern of investment across acute and preventive services?
- E.8** Which approaches do you think are likely to be most successful and why?
- F. **The last section concerns the concept of public health governance****
- F.1** How would you describe the stewardship role of the PCT with regard to its local population?
- F.2** How is this reflected in practice?
- Board commitment to public health and monitoring of public health targets
 - Commissioning priorities?
 - Upstream/downstream approaches?

- Emerging public health hazards?
 - Health inequalities?
 - Patterns of investment?
 - Approaches to the wider public health system?
 - Public accountability?
 - Partnerships?
- F.3** What systems of governance do PCTs need to have in place if they are to demonstrate effective stewardship of the health of their populations?
- Joint arrangements?
 - Integration into Board governance procedures?
- F.4** For PCTs in general, what would you see as examples of a failure in public health governance?
- F.5** How can governance failure in public health (in the sense of stewardship) be measured?
- F.6** For PCTs in general, what would you see as examples of governance success in public health?
- F.7** How can governance success be measured?
- F.8** What are the current barriers to an effective system of public health governance?
- Leadership issues?
 - Ownership and accountability?
 - Dominance of clinical governance?
 - Board priorities?
 - Accountability to the public?

Finally

- Is there anything else you would like to add?
- Are there any comments you would like to make on the interview and the interview process?

Are there any documents or information you would like to recommend?

2. Interview schedule for practice-based commissioners (phase two)

A. Background

- A.1** First of all, could you describe your current role (*for new interviewees*)/ have there been any changes in your role (*for follow up interviews*) since the last interview?
- A.2** How would you describe progress in PBC in general terms since the last interview?
- A.3** Could you describe how PBC is currently structured in your PCT?
- Number of PBC groups/clusters in area?
 - Membership structures of clusters/groups?
 - GPs only/AHPs/practice managers/health trainers?

- Patients/public?/LINKs?/shadow boards?/other?
 - Do you have any plans to change membership?
- A.4** How would you describe the emphasis on health and well being services in strategies developed through PBC in your area?
- About right?
 - Not enough emphasis?
 - Has it shifted in any way?
- A.5** Are there any plans further to develop health and well being services?
- A.6** How would you describe the emphasis on health and well being services in your PCT?
- About right?
 - Not enough emphasis?
- B.** The second section explores changes in commissioning arrangements since the first phase interviews and the impact of these changes on commissioning for preventive services and addressing health inequalities. It begins by looking at general issues of commissioning through PBC and then focuses on services for health and well being.
- B.1** Could you describe the processes through which your PBC group(s) currently:
- Agree commissioning priorities across the cluster(s)?
 - Influence annual commissioning intentions in your PCT?
 - Influence longer term PCT commissioning strategies?
 - Involve the public/patients?
- B.2** How would you describe the role of PBC at present?
- Influencing strategy?
 - Developing care pathways?
 - Helping to reconfigure services?
 - Commissioning services
 - From others?
 - Through general practice?
- B.3** How do you think the role will develop over the next year or so?
- B.4** Do you consider that current PBC and PCT commissioning strategies are well aligned?
- If not, how could alignment be improved in your view?
- B.5** Have any governance tensions emerged through PBC acting as both commissioners and providers?
- If yes, how have these tensions been resolved?
- B.6** Moving on to commissioning for health and well being, how would you describe the involvement of PBC in this area?
- Specifically:
- Is there public health team support for practice-based commissioners in developing their strategies and plans?

- Have practice-based commissioners been involved in developing the JSNA or using it to inform their commissioning priorities/strategies?
 - Have practice-based commissioners been involved in choosing health outcomes and in setting local public health targets?
 - Are practice-based commissioners involved in joint commissioning with the local authority on services related to health and well being?
 - Is there any involvement of practice-based commissioners with LSPs?
 - Is there any involvement of practice-based commissioners in developing local area agreements?
- B.7** How would you summarise support to PBCs from your PCT in relation to developing the health and well being agenda?
- Examples?
- B.8** Have practice-based commissioners been involved in commissioning preventive services
- From GP practices? Give examples
 - From other providers? Give examples
- B.9** What would make PBCs more likely to engage in commissioning health improvement services?
- B.10** Could you describe the barriers?
- B.11** Could you describe whether the QIPP initiative is likely to influence the ways in which commissioning will be carried out over the next year within PBC and, if so, in which ways? (QIPP – Quality, Innovation, Productivity and Prevention)
- B. The next section explores contractual arrangements and incentives related to health and well being**
- C.1** Could you describe any changes in primary care contracting mechanisms?
- Increased use of APMS/PMS?
 - Changes in performance management of primary care by the PCT?
- C.2** Is a preventive component included in
- APMS contracts?
 - PMS contracts?
- C.3** Which incentives are currently in place to encourage additional preventive services in primary care?
- Local Enhanced Services element of the GMS and pharmacy contracts? Give examples?
 - Local QOF schemes?
 - PBC incentive schemes?
 - Use of freed up resources? How arranged?
 - Through CQUIN? (Commissioning for quality and innovation)

- C.4** How would you see the balance between contractual and incentive-based approaches developing over time?
- C.5** What in your view would be the most effective ways of incentivising the commissioning and provision of preventive services?
- C.6** Are financial incentives the most important lever for change in PBC?
 - Are other kinds of incentives important and if so, which ones?

D. The fourth section looks at performance management systems, regulatory arrangements and standards and their impact on commissioning for health and well being.

- D.1** It has been argued that performance management systems have not encouraged a shift in emphasis from acute services towards the health and well being agenda? Does this still apply?
 - Role of Care Quality Commission (CQC) in assessing health and well being?
 - Role of Comprehensive Area Assessment (CAA) in assessing health and well being across a local area?
 - Role of SHA in performance management of prevention/health promotion?
 - Vital signs?
 - LAAs?
 - Other?
- D.2** How engaged are PBCs in these performance management systems?
 - Monitoring public health targets?
- D.3** How would you describe the impact of WCC and WCC assurance processes on PBC over the last year or so?
 - Greater emphasis on preventive services?
 - Greater emphasis on partnerships?
 - Degree of integration of PBC with WCC assurance processes?
- D.4** In practice, which areas of performance management predominate for your PCT?

E. The fifth section focuses in more detail on decision-making and investment for health.

- E.1** What is the process for agreeing priorities for investment within your PBC group or cluster?
 - Modelling costs and investments over short, medium and longer terms?
 - Looking across pathways of care?
 - PBMA?
 - Disinvestment strategies?
 - Changing pattern of investment across acute and preventive services
 - Extent to which methods of economic evaluation are included?
- E.2** Which methods, if any, would it be useful for PBCs to adopt?

- E.3** Are practice-based commissioners involved in deciding PCT commissioning priorities?
- E.4** Is it possible to identify preventative health spend within the indicative budget?
- If yes, how is this defined, what issues emerge, and is documentation available?
 - If no, are there plans to do this?
- E.5** What are your views of the feasibility of using preventative health spend as a measure?
- E.6** How much flexibility is there in budgets to shift the emphasis towards health and wellbeing?
- For example, how are decisions made over reinvestment of freed up resources?
- E.7** Could you describe any plans to rebalance investment towards health improvement?
- E.8** How could PBCs be encouraged/ what would enable PBCs to shift their spend into longer term health and wellbeing outcomes?
- Barriers?
- F. The final section looks at the stewardship role in relation to the health of the local population.**
- F.1** Do practice-based commissioners have a stewardship role with regard to the local population in addition to the care of individual patients?
- F.1a** What does this mean to them?
- F.2** How is this reflected in practice?
- Through commitment to public health and monitoring of public health targets?
 - Through influencing PBC/PCT commissioning priorities?
 - Through balancing upstream/downstream approaches?
 - Through identifying emerging public health hazards?
 - Through acting on health inequalities?
 - Through shifting patterns of investment?
 - Working in partnerships?
- Finally**
- Is there anything else you would like to add?
 - Are there any comments you would like to make on the interview or the interview process?
 - Are there any documents or information you would like to recommend?

Appendix 3 Snapshots of case study sites

The following brief descriptions of our ten case study sites draw on interview data from first phase (2008-9) and second phase (2009) interviews and documentary analysis. Many features were common to all case study sites, paralleling the performance-related demands of the WCC assurance process. This included financial and strategic alignment, addressing the eleven commissioning competencies and prioritising ten health outcomes, including the reduction of health inequalities. WCC had led to a more systematic approach and most sites were adapting their organisational structures to fit demands of WCC and the commissioning cycle. All sites had joint and specialised commissioning arrangements in addition to lead commissioning responsibilities.

Data from the Healthcare Commission is drawn from the 2006/7 Annual Health Check and WCC scores are based on the 2009 assurance process. In order to preserve anonymity some post titles have been changed and some details omitted where this could serve to identify the location of sites.

Site one

Site one was an ethnically and culturally diverse non-Spearhead PCT with a population of over 250,000, located in outer London and co-terminous with the local authority. Life expectancy was better than the English average but rates of TB and diabetes were high, as was child poverty and homelessness. There was a high turnover of population.

At the time of first phase interviews its public health rating was good but use of resources was weak. In the CQC assessments for 2008/9, quality of commissioning services was fair, financial management was now rated good, and 'providing services' (core standards) partly met. The PCT was located in the fourth quartile of the 2009 WCC assessments.

The PCT had undergone rapid change, achieving financial turnaround within a year under a new PCT Board. The DPH was a joint appointment with the local authority and public health was well integrated into governance arrangements and strategic development. At the time of first phase interviews there were plans to realign the structure of the organisation around the requirements of WCC.

The effects of financial stringency were still evident with the public health team described as understaffed. Resources for prevention, including those for smoking cessation, had been cut back during the period of financial instability but were now reinstated and included pharmacy involvement. However, some staff had been lost.

Relationships with the local authority and with the voluntary sector had also suffered but partnerships were now on a better footing. Governance arrangements for joint commissioning were being reviewed and the integration of children's services needed development. The LSP was

described as 'vibrant' but themed partnerships had only recently been developed. The CSP outlined areas where health and well being were jointly funded and noted that for the programme budgeting category 'healthy individuals', this PCT was in the bottom 10% of PCTs.

The DPH report and the JSNA (2007/8) were published as a joint document and considered a success. The JSNA had been developed early, informing LAAs, the annual operational plan and the health and well being strategy. As it coincided with a period when PBC was still forming, there had been no input from practice-based commissioners. There was also limited involvement from the VCS. The report did not focus on commissioning objectives or on locality-based commissioning. AAACM was not included as a LAA target.

The majority of GPs were in single or two-handed practices: primary care services were in need of development and there were plans to undertake QOF reviews to assess quality. APMS contracts were viewed favourably as a means of providing greater flexibility. While there were a number of LESSs linked to the achievement of 'Vital Signs' targets, their use in incentivising preventive services was relatively limited.

PBC had suffered in 2007/8 as a result of financial turnaround where incentive payments were not forthcoming, but over the previous year it had made progress, with good engagement from practices. There were five cluster groups, each with two representatives on an overarching Federation Board and there were additional incentives to commission for a population of over 50,000. There was also a PBC governance and approvals committee. The current emphasis was largely on managing demand and service redesign and, as in many other sites, investment in prevention was premised on managing demand for acute services. Health and well being was described as needing further development. There were mixed views on the alignment across PBC intentions and PCT strategy. The AOP and CSP made little reference to PBC in 2008/9.

One impact of the financial turnaround had been the implementation of rigorous business plans and investment processes and public health benefit was considered as part of this. This was a formal process with an investment panel considering project briefs according to a structured pro-forma and then reporting to the PCT Board. Skills in using decision-making tools, such as PBMA, were considered in short supply. Making the business case for health and well being remained difficult, given problems in quantifying long-term benefit, compounded by the fact that a highly mobile population made modelling and identifying longer-term approaches more complicated.

Patient and public involvement in the PCT was described as in need of development, although a public engagement strategy group had recently been established with representation from the local authority, voluntary organisations and others. There were cultural, educational and language barriers to public involvement and some interviewees described public involvement in decision-making as poor. It was also argued that local

priorities were inadequately reflected in nationally-driven performance management regimes. Social marketing was being developed to try and improve take up of preventive services.

The VCS was described as relatively less well organised than in other London boroughs and this made it more difficult for their views to be represented. Moreover, as in many other sites, certain sectors from the VCS tended to monopolise decision-making. The period of flux through financial turnaround had also been destabilising for the VCS with closures and ambiguity over contracts. The Compact was described as not working well at present. While the VCS had been commissioned to provide services such as counselling and mental health initiatives in schools, it was argued that their potential to be equal partners with responsibility for delivering targets should be developed. However the smaller VCS organisations could find it difficult to compete for contracts. Nevertheless, there were examples of the VCS being commissioned to provide specific health and well being services.

Given the high turn over in population there was often a delay in identifying community needs. Previous progress in community development as part of the former Health Action Zones appeared to have been lost yet this was seen as crucial for promoting health and well being in the area.

The LINK was not established at the time of the interviews but a representative from the former PPI had a seat at the PCT Board. As in other sites, relationships between the OSC and the LSP were poorly developed, but the OSC had scrutinised the health and well being strategy and monitored LAA targets.

In second phase interviews there had been further developments in the engagement of practice-based commissioners and the VCS in the JSNA and a new public and patient engagement strategy was in place. There were plans to incorporate preventative aspects in acute contracts and the QOF was now actively performance managed. There were also plans to reduce the use of LESs due to cost constraints. The LINK was involved at board and cluster levels but still developing its role. The importance of maintaining public health input in cross-PCT acute commissioning was emphasised, as was the importance of extending public health input into PBC.

Site two

Site two was a large PCT covering a rural county with a growing population of almost 700,000. The PCT was an amalgamation of three previous organisations and included one designated Spearhead area. While there were pockets of deprivation, the population as a whole experienced better outcomes than the England average. The PCT had recently moved into financial balance. At the time of first phase interviews, use of resources was weak, and achievement of new national targets was fair as was the quality of services. In the 2008/9 assessment, quality of services and financial management were both fair and the 'providing services' category was 'partly met'. It was located in the third quartile of the 2009 WCC league table.

The PCT spanned one county council and numerous district authorities, each with its own LSP, which created difficulties, including developing and agreeing priorities, negotiating across county and district priorities and providing the resources required to participate in a large number of LSPs. Public health input across such a large geographical area was inevitably complicated and had to be targeted on key decision-making activities. The organisation was established around the commissioning cycle, with public health input into the PCT planning board which also included the Director of Children's Services and the Director of Adult Services.

The PCT Board was recognised as committed to a health and well being agenda with a shift in focus towards health promotion and targeting inequalities. The DPH was regarded as highly proactive and the annual DPH report as influential. The post was not a joint appointment although there were a number of joint posts in existence. The DPH report considered commissioning issues, identifying priority areas, making commissioning recommendations and identifying services which had been commissioned, or should be in place, to address needs. The DPH report also discussed PBC in detail, including how the PCT worked with PBC clusters to identify variation in QOF scores. It also considered locality-based commissioning, presenting detailed locality profiles through which commissioning objectives were targeted, identifying the importance of relationships between PBCs and LSPs and ways in which the PCT, practice-based commissioners and local health partnerships could work together to achieve strategic aims.

A county-wide approach had been taken to the production of the JSNA and this had been enabled through a well-established, county-wide data repository, funded through all the districts, the county, the PCT and the police. This provided the basis for a shared evidence base and had been in place since 2000. It was considered well-integrated into board decision-making. Although there had been involvement of different partners in the JSNA it was acknowledged that further input was needed. There appeared to be alignment across LAAs, PCT plans and PBC plans and the effect of joint working on LAAs was described as having been beneficial to the development of local partnerships. The CSP demonstrated how LAA indicators or priorities were aligned to PCT Vital Signs indicators and it was possible to deduce how these aligned to WCC outcomes. AAACM was included in the LAA and the PCT and local health partnership board were lead partners

In first phase interviews, there was a jointly-managed public health provider arm with a mixture of County Council and PCT employees. There were pooled budgets with the local authority in relation to health and well being with a substantial health and well being fund focused on deprived areas, managed through the local authority and funded by the PCT. There were also integrated structures across health and social care as well as across health and well being.

Spearhead status was not considered to have exerted any influence on preventive services: indeed soon after Spearhead status was announced there had been cuts in public health services due to cost constraints.

However, it had acted as a catalyst for partnership working across the Spearhead area within the PCT.

General practice was equally divided between PMS and GMS practices. The use of LESs to incentivise health and well being services was limited as such services, including smoking cessation services, were mainly arranged through partnership working with the local authority. There was, however, an example of a LES to address inequalities in access and outcomes for BME groups. The PCT had also provided rewards for innovative working, including recognition of a smoking cessation scheme run by midwives.

Each cluster had an executive who was represented on the PEC and through the PEC to the PCT Board. There had been good progress in pathway development spread across the clusters. Each cluster had a representative from public health and informatics. Cluster-specific public health reports were produced to include data on premature mortality and areas of strength and weakness. Clusters had varied interests and there were also different approaches to cluster membership of other NHS professionals, or of local authority representatives. While involvement in health and well being was varied, there were examples in one PBC cluster of preventive services (related to obesity and physical activity) commissioned from the VCS and also the use of FUR for health and well being initiatives, such as prevention of teenage pregnancy, a health café and health trainers. The CSP described how a joint commissioning event ensured PBC plans were captured in PCT plans and were aligned to local authority plans. The role of PBC in working towards the 11 WCC outcomes was also identified.

There had been a year-long and widely-publicised exercise to engage the public in the principles and criteria for investment in the health and well being agenda. This had involved thousands of people and involved a number of different consultation methods, including focus groups. Practice-based commissioners had also started to hold public meetings over their plans. The PCT was considered proactive in engaging with the VCS, arranging for the delivery of projects clearly related to health and well being targets. Innovative approaches were being developed to reach young people, for example, through the use of YouTube to publicise Chlamydia screening.

Representation of the VCS on the various LSPs varied according to their presence in a particular locality as, given the large geographical area, relatively few VCS organisations worked county-wide. The VCS had been involved in setting LAA targets at district level but the system of County and districts raised issues of how far VCS decisions at district level were reflected at county level. While there was an overarching county-wide VCS group to provide a more concerted voice and a compact had been agreed across the county, the range and diversity of organisations made it difficult to liaise and reflect views. The view was expressed that the VCS ought to be more involved in decision-making and that public involvement was largely tokenistic. It was argued that the VCS could be better deployed in helping the PCT meet its targets, building on their current activities. In the previous year however, the VCS had become more involved in delivering PCT-funded

projects and initiatives. The LINK was described as still at an early stage and was not discussed in any detail.

While programme budgeting was beginning to be used, the CSP acknowledged limitations of programme budgeting data.

By the second phase, the joint provider arm had disappeared, there was still very limited awareness of the LINK and marked variation persisted across PBC clusters, which were seen as relatively isolated from each other with delays in getting plans off the ground.

Site three

Site three, a non-Spearhead area, had a population just under 230,000. The PCT was co-terminous with the unitary authority. The population was increasing (and historically undercounted) and with a younger profile than the national average. Health was similar to the England average but with significant inequalities within the PCT area, with relatively high smoking levels and a failure to meet smoking cessation targets at the time of first phase interviews. The PCT had not been reorganised in 2006, but there had been internal reorganisation. Use of resources was rated weak, public health developmental standards good and quality of services was rated fair in 2006/7. In the CQC assessment of 2008/9, quality of commissioning services was rated good, financial management was fair and 'providing services' partly met. It was located in the second quartile of the WCC league table.

The PCT had moved from being overspent to being in financial stability which made it easier to shift patterns of investment. The skills learned through the period of financial pressure meant that tight budget management was in place. Commissioning for health and well being was described as core for the organisation and there was a public health-led approach to commissioning, developed over the previous year and following the appointment of new senior posts. The priority accorded to health and well being was reflected in strategic development, in methods for defining and tracking preventative health spend, in a commitment to increase preventative health spend by a certain percentage each year and in the use of LESs to incentivise preventive services in primary care. Growth monies had allowed for additional resources to be allocated to prevention and this was reflected in the strategic plan.

There was a particular emphasis on innovation, motivation for improving health and well being throughout the organisation, strong leadership and on the key role played by joint appointments across the PCT and the local authority, including the DPH. There was a tradition of joint working and senior joint public health appointments. Clinicians were well represented amongst PCT Executive Directors. Public health was described as involved in commissioning rather than simply 'advising commissioners', developing strategy as well as carrying out health needs assessments. The CSP noted that PCT commissioning intentions aligned with LAA priorities and also with WCC outcomes. Health inequalities were included in the LAA, supported by three indicators: difference in life expectancy between most and least

deprived quintiles of the wards; number of 4 week smoking quitters; and number of smoking quitters in the 20 most deprived parishes. The PCT led on the AAACM target. Interviewees considered it important to focus on issues lying behind the targets rather than the targets *per se*. It was also argued that the alignment of targets achieved at a local level (and enabled by joint performance management posts) was less evident at SHA/GO levels.

There was a focus on integration across health and social care reflected in the activities of a voluntary joint health and social care board and pooled budgets. There were joint activities related to health and well being, for example, working across education and health in relation to obesity. There were also a number of integrated services including those for older people. Both the PCT Chair and the CE sat on the LSP at the time of the interviews. However, the local authority was going through a period of instability with a large number of interim appointments and this had served to undermine the development of stable partnerships and joint commissioning. The LSP had only recently established its six thematic partnerships.

The first JSNA had benefited from a history of joint working and joint data sharing through a shared observatory which brought together a wide range of data from health and social care and the police. It was developed with a local commissioning federation (which included patient representatives and the VCS). However the JSNA did not discuss the role of PBC in commissioning services to address health inequalities and health promotion/prevention or locality-based commissioning. The AOP had little discussion of PBC or on joint commissioning arrangements. There were plans to develop a more radical approach to the JSNA in subsequent years.

Although it was considered that partnership governance required development there was a line of accountability leading through the JSNA, the sustainable community strategy, the LSP the LAA and the scrutiny function.

Practices were evenly divided across GMS and PMS: many had previously been fund-holders and welcomed more involvement in decision-making. Roughly one quarter of practices had patient participation groups. LESs were being more widely used in general practice and in community pharmacy, and were intended to encourage a more proactive approach to promoting behaviour change in relation to smoking cessation or alcohol reduction. There were LESs for smoking cessation, Chlamydia screening, brief interventions and alcohol with many being modified for community pharmacies. As in other sites, it was considered that performance monitoring of primary care could be improved and there were also discussions over increased use of APMS contracts.

PBC was considered well-developed with commissioning and provider aspects kept separate and a single collaborative in place which simplified prioritisation processes. Membership of the collaborative included practice managers, nurses and a patient representative.

There was evidence of practices becoming increasingly interested in commissioning rather than just in providing services, work on clinical pathways was in progress and some practices had set up services to which other practices could refer. PBC was considered an important route for communicating with general practice although clinical engagement still needed development. However, it had not yet proved a source of major changes in commissioning. An innovation fund had been used to stimulate development, for example, using practice websites as an interface between practices and the public. Practices had also been paid for carrying out audits to provide data not available from secondary care. However, there was some scepticism over how far PCT savings would result from PBC initiatives.

PCT and PBC commissioning was described as integrated, with PBC proposals considered by the PEC, as were proposals from planning groups. Commissioning and provision were kept separate and practices making proposals would not necessarily be commissioned to provide those services.

Patient involvement was described as well integrated into decision-making. Workshops on prioritisation for WCC had also been held. The LINK was considered as one, but not the only route into the VCS. There was active involvement of the LINK at PCT Board level, where the chair was a non-voting member, and nominated LINK members were involved in working groups, tender panels, specifications and pathway redesign. Involvement of the LINK with the local authority was less well developed. Minutes of LINK meetings were shared with statutory organisations to keep channels of communication open.

The LINK was one of the first to be established nationally and was an active presence in the PCT and closely involved with the scrutiny panel. An interim executive committee for the LINK had been established pending elections, and there was a support organisation and a website. Membership would be evenly divided between organisations registered with the LINK, individual LINK members and others. They had built on aspects of the former PPIF including a panel, now extended to encompass both health and social care with over 300 members, available for surveys, or to act as representatives. The panel had good representation from minority groups. The LINK also held an annual showcase of voluntary and statutory organisations. They were setting up a database of organisations and had negotiated training for lay members of committees. Governance arrangements were being developed which would include an annual citizens meeting and there were also plans to bring together patient participation groups based in GP practices to help coordinate views. There were, however, potential tensions between the LINK and the overarching VCS group.

There were large numbers of small voluntary organisation staffed by volunteers which made representation difficult but their close links with different communities could be better exploited. Commissioning from the VCS was considered in need of development.

The OSC health panels had scrutinised aspects of health and well being and emphasised direct communication with the public. However, the health

panel did not link with other OSC sub-groups or with the JSNA. As in other sites, relationships between the OSC and the LSP appeared underdeveloped (as were links between the LINK and the LSP) and there was little awareness of the role of the HPA locally.

The business case for health and well being was made alongside other business cases and return on investment had to be demonstrated. Extensive use had been made of programme budgeting. Bids for each of the strategic priorities were coordinated and prioritised by leads who were public health consultants and then discussed by the PEC. There was a commitment to shift half of one per cent of the budget annually into preventative care (2008-12) and one per cent annually from secondary to primary care.

Programme budgeting had been used in financial planning and to identify where spend was lower or higher than the national average, although, as elsewhere, limitations of the data were acknowledged. In the 09/10 AOP the PCT was identified as having a consistently higher spend on the 'healthy individuals' category than the national average. While plans suggested that the PCT was considering including health promotion and prevention in acute contracts, incentives to engage providers were largely focused on primary care.

In second phase interviews the influence of the LINK was recognised, as was the success of LESs in achieving targets for smoking cessation. There were discussions over how contracts could be reconfigured to promote a focus on outcomes rather than activity across pathways of care.

Site four

Site four, a Spearhead site, resulted from the merger of two previous primary care organisations and had experienced many recent changes of personnel. It covered two separate local authorities, both Spearhead areas, and had a population of almost 300,000. Health was worse than the England average with high smoking rates, life expectancy amongst the worst in the country for one of the boroughs and high levels of inequalities in each. Use of resources was rated fair but quality of services and new national targets were rated good. In 2008/9 quality of commissioning was good, financial management fair and 'providing services' fully met. It was located in the second quartile of the 2009 WCC league table.

Commissioning was complex due to the reorganised PCT spanning two separate boroughs and also acting as either lead or associate commissioner for different hospitals. The DPH was jointly appointed across both boroughs and the PCT and there were separate LSPs, health and well being partnerships of the LSP and two JSNAs. However alignment of LAA targets had been achieved. There were also wider partnership arrangements across local boroughs. Despite the importance of partnership working being recognised in the DPH report, there was little discussion of joint commissioning arrangements in the AOPs. However there were examples of preventive programmes in relation to 'healthy weight' initiatives commissioned across both boroughs.

A sound financial footing had made it possible to invest in health and well being and there were also jointly-funded health improvement initiatives across the boroughs and the PCT. Moreover, efficiency savings for substantial investment in health and well being had been identified for the subsequent four years, described as a 'sizeable leap' in investing beyond the health agenda into the well being agenda. As a pilot for the WCC assurance process the PCT had an early start in developing a systematic commissioning process. There was considered to be a strong and consistent commitment to health and well being at PCT Board level and strong clinical engagement in the development of strategic priorities. Addressing health inequalities was described as 'centre stage' with the Chair taking an active role in both of the health and well being partnerships. A public health-led model of commissioning was described, with the needs of the population as 'a driver with passion ' and reflected in the integration of strategic with public health roles. Performance management was not generally seen as the main driver for this work which was part of the PCT mission and ethos. However, some interviewees considered targets essential to shift the focus to health and well being. A stewardship role was seen as reflecting the needs of the population and also improving public involvement in commissioning.

The JSNAs were seen as positive with both public and PBC support. There was extensive public involvement in their development with over 3000 responses gained through a large consultative exercise, leaflet drop and media campaign, although, as for other sites, the timing of the introduction of the JSNAs did not allow for the effect on commissioning intentions to be evident in the first year. Documentary analysis demonstrated some differences between JSNAs, with one discussing commissioning for health needs to a greater extent making broad commissioning recommendations to address identified needs. Neither JSNA discussed the role of PBC in detail. Whilst both mentioned how the JSNA should broadly inform decision-making, one considered this in more detail at a local level. The JSNAs were described as largely reflecting the direction of travel already underway. There were some issues over integration and sharing of health and local authority data.

The DPH reports also identified commissioning objectives, including some areas where joint commissioning would occur. Both reports considered progress of existing services and the most recent report provided detailed information on partnership initiatives intended to improve health outcomes. These included getting people with long-term conditions back into work, health trainers and 'fit for life' campaigns.

GPs in one of the boroughs were mainly on PMS contracts and on GMS contracts in the other. Four PBC consortia (two in each borough) were engaged in identifying strategic priorities and the PCT was widely viewed as supportive to PBC. The commissioning activities of the consortia were integrated with the PCT and governance systems were in place which held PBC consortia to account for delivering agreed priorities which were also linked with the LAAs. The alignment of PBC schemes with the PCT and LAA

priorities had been achieved due to increased public health input into PBC consortia however there were no examples of health and wellbeing initiatives from PBC at the time of the interviews. As in most other sites, links between PBC and the development of the JSNA were not well developed although business plans developed through consortia had to relate to the JSNA.

Public involvement was included as part of the PBC LES, which required patient groups in practices also to consider PBC consortia business; the PBC LESs also encouraged a more proactive approach to PBC. In considering PBC, the most recent DPH report considered their role, the need to integrate them into the public health agenda and the need for PBC to take the lead in new service developments to deliver improvements in priority areas.

The compact with the voluntary sector in one of the boroughs had been updated to reflect procurement and tendering procedures. There was a directory of voluntary organisations highlighting areas where the VCS could contribute to strategic outcomes. The LINKs were still being established and seemed largely modelled on the former PPIF. As in other sites, the VCS was keen to have stronger voice in decision-making.

Priority-setting was under development as was the movement from 'broker to commissioner'. It was considered difficult to identify preventative health spend as prevention could be included in many professional encounters.

In second phase interviews additional funding had been directed towards LESs although it was envisaged that in the future changes in the contract would be needed and LESs reined back. A QOF plus scheme had also been implemented.

Site five

Site five was a deprived London inner-city borough with Spearhead status, co-terminous with the local authority and with a relatively small population of just over 200,000. Health was well below the average for England with high levels of obesity and of children living in poverty. Although much of the borough was amongst the most deprived areas in England, there were also extremes of wealth. Use of resources, quality of services and new national targets were all rated as good in 2006/7 but in 2008/9 quality of commissioning services was weak (related to waiting times in secondary care), while financial management was good and 'providing services' fully met. The PCT had moved into financial stability and was in the highest quartile of the 2009 WCC league tables.

Leadership was consistently described as good or 'inspirational'. The last three or four years had seen increased investment in partnership working and strategy development with the local authority and also with the VCS, partly spurred by new leadership, social commitment and encouraged by government policies. Commitment to partnership was evident throughout the organisation and reflected in an award-winning health and well being strategy developed in partnership with the local authority. There had been a

major shift in focus towards health and well being with a substantial investment in health improvement and tackling health inequalities, largely funded through growth monies. There was a particular emphasis on improving access and quality in primary care, gauging how primary care should be developed to meet the health needs of the PCT's population.

There was a well resourced and effective public health team, a joint DPH and good links with primary care. However, some of the difficulties inherent in joint posts were also discussed. Every provider team had a public health champion. The intention was further to integrate a public health perspective throughout the commissioning cycle. However the test would lie in the extent of implementation and the impact on outcomes and there was still need for more partnership working with the local authority on wider determinants of health. They were not pooling budgets but working with the LA as partners in commissioning within the healthy lifestyles agenda.

An earlier detailed health needs assessment (2008) had largely been developed by the PCT rather than jointly. The latest JSNA had been developed with involvement from clinical leaders, PBC, PPIF members, the PEC, the local authority and the voluntary sector and was described as an important catalyst, highlighting areas without robust investment plans. As in other sites, there were differences in the ways that health needs assessment was understood across the local authority and the PCT and some debate about the extent to which the JSNA informed prioritisation processes in PBC. The CSP clarified areas which would be worked on in partnership as well as lead partners for each priority. The CSP also considered the role of PBC in care pathway development and service redesign. AAACM was included in the LAA with both the PCT and the LA as partners for delivery. The AOP (09/10) had additional information on areas which would be commissioned or provided in partnership.

There were thirty six practices which were all engaged in a single commissioning consortium. The PBC executive consisted of eight elected GPs with representation from practice managers, practice nurses, allied health professionals, community nurses and patients. Executive Directors of the PCT attended meetings. The PBC executive fed into the PCT Board via the PEC (which also had wide membership) and was involved in the JSNA and in the commissioning process. The initial focus was on service redesign and a separate prioritisation process. An emphasis on collaboration across practices was reflected in PCT plans to develop federated networks which would aid cross-practice collaboration and sharing of skills, reflecting growing practice sub-specialisation. The networks would be aligned with the local partnerships and district nursing teams would also be aligned with the networks.

Unusually, savings made through PBC were shared on a 50/50 basis, with 50 per cent going to practices making the savings, 50 per cent pooled across practices for larger developments and nothing reverting to the PCT. Local public health initiatives were being developed through practice savings. However, the non-recurrent nature of FUR was considered an inevitable barrier to developing a longer-term approach to service

development and there was some debate over how far PBC and PCT commissioning priorities were aligned.

PCT plans considered contractual levers, including improved contract management in primary care to deliver the strategy and improve health and reduce inequalities. The 09/10 AOP stated specific health promotion/prevention initiatives, such as smoking cessation, would be included in acute contracts. LESs appeared to be an important route for incentivising preventative care, and included a high risk CVD LES and diabetes LES both of which aimed to encourage GPs to identify those at risk, enter them on a register and manage their condition.

Despite the use of large numbers of LESs to address health inequalities and health improvement, it was considered that only some had worked well and there was scepticism about their continued use. It was argued they should be more systematic and uniform, or focus on generic areas such as a consistent approach to motivating behaviour change as a common theme across areas such as self care and healthy lifestyles. They could also be developed to purchase a package of care across a network. Incentives were considered as only part of the picture and there were limits to achieving change through a purely contractual approach. Levers for change were considered inherent in commissioning plans and in targeted investment arising from them.

The emphasis on partnerships and public involvement was also reflected in a locality focus with geographically-based local partnerships bringing together service providers, residents and councillors across populations of about 35,000 which fed into the sub-groups of a borough-wide partnership Board. Although slow to get established, the LINK had representation from residents, users of the VCS and VCS providers. There was also a LINK representative on the PCT board and an intention for them to get involved at each stage of the commissioning process.

There was a large VCS, but no umbrella organisation at the time of the interviews. The VCS was widely used to identify local health needs, contribute to strategy development and to provide health improvement services such as smoking cessation, healthy lifestyle initiatives and health trainers. There was patient and public involvement in each of the major programme areas and in clinical service redesign. All practices had patient involvement groups.

Programme budgeting was used to identify outliers in terms of spend and had been used to identify: spend per 100,000 weighted population for the PCT; the average spend per 100,000 weighted population for the PCT "cluster"; and the average spend per 100,000 weighted population for England. It appeared that spend on the healthy individuals category was higher than national and cluster averages. There was an intention to use PBMA in order to quantify the impact of commissioning changes with greater precision. However there was some scepticism expressed in the interviews over data quality.

Given the focus on health and well being, debates were largely focused on prioritisation across public health and primary care rather than across health and health care. However, as in other sites, the focus had been on growth money and not on methods for prioritising across total spend. Reductions due to changes in the allocation formula could also create difficulties.

By second phase interviews joint working had improved, The LINK was involved in the JSNA and the GPs were informed (although not actively involved). PBC had become more locality-focused, with a more geographically balanced input across the borough. Each local area also had a network of practices – and there had been incentives to encourage GPs to work collaboratively in these networks. There was discussion over developing network contracts for areas of care, such as diabetes. Networks would also be co-terminous with the local authority localities and involve local authorities as well as other partners, although it was still unclear how this related to PBC structures or how the networks would fit into PBC commissioning strategy. However, interviewees saw potential for improved joint working at a local level on the health and well being agenda.

Public health input into the networks and the localities had been strengthened through the appointment of Healthy Lifestyle Programme Managers, but PBC had not generally focused its attention on the health and well being agenda. The PEC had been restructured and had a wider membership. Public involvement continued to be taken seriously and health trainers, for example, had been recommissioned following public consultation. As in other sites, concern over the impact of financial stringency on the preventive agenda was more evident in the second phase interviews.

Site six

Site six was a Spearhead area, co-terminous with a metropolitan borough, with a population of around 300,000 and the result of the merger of four former PCTs. Health was generally worse than the average for England with marked health inequalities within the PCT area. The PCT was rated fair for use of resources, good for the quality of services and excellent for new national targets. In 2008/9 quality of commissioning services was good, financial management was fair and the category 'providing services' was almost met. It was located in the top quartile of the 2009 WCC league table. The PCT was in financial stability at the time of the interviews.

PCT priorities were described as public health priorities with public health embedded throughout the commissioning process. There was strong public health leadership in the PCT and the public health team was described as involved in every aspect of the commissioning cycle.

The DPH was a joint appointment across the PCT and the local authority and a member of the corporate management team at the local authority, but without line-management responsibilities. Strategy was orientated towards health and well being and PCT resource (funded through financial surplus) to the value of several millions was identified specifically for 'health

turnaround' projects mainly for preventive services. A number of these had been jointly commissioned with the VCS from the voluntary sector with details of projects available in the local delivery plan. The CSP also emphasised the importance of partnership working, identifying 'spotlight' initiatives which would be tackled by LSP subgroups. There had been funds for health inequalities programmes over the previous two years and funds had also been guaranteed for the following two years.

The public health team had led on the JSNA which included community profiles for each of the communities in the PCT, with enhanced profiles for disadvantaged areas. The JSNA had encouraged data sharing and linked data sets across the PCT and local authority.

There were no formal pooled budgets and joint commissioning had been slow to develop, but there was some joint commissioning with the local authority in health promotion in areas such as exercise on prescription and healthy school meals as well as joint posts in children's services and mental health. There was also joint commissioning with the local Council for Voluntary Services for services delivered by through the voluntary sector. As in some other sites there was discussion about the parameters of the local role of the health protection agency and in this case, a health protection strategy had been produced for the city to identify gaps and inform engagement with the national health protection strategy.

Strategic priorities were aligned with the LAA and the AAAAM indicator was included as part of the LAA. There was a performance management software tool shared with the local authority, used for joint monitoring of LAAs.

There was one large PBC consortium covering the vast majority of practices and two much smaller consortia, but all practices in the PCT were involved. Membership of the main consortium was currently made up of GPs and PCT representatives, including public health, which provided practices with health profiles of their populations. There were agreed governance arrangements between the main consortium and the practices as well as between consortia and the PCT.

There had been good progress at a corporate level in PBC over the previous year, described as genuine involvement, well integrated into the overall strategy and strategic priorities and with input into commissioning decisions, the annual contracting round with the acute sector and service redesign. A number of PBC business proposals had been implemented, including lifestyle initiatives. There was a willingness by practices to invest in health and well being initiatives as long as effectiveness could be demonstrated: they were also contracted to address health inequalities. However, there appeared to be little involvement of PBC in developing the JSNA: governance tensions remained over PBC being both commissioners and providers and the extent to which PBC representatives represented individual practices or the consortia. There was little discussion in the CSP of PBC involvement in the health and well being agenda or of incentive schemes. The role of PBC was, however, considered in the DPH report: the

reduction of health inequalities was stated as a key principle of PBC commissioning plans and PBC care pathway work. Service redesign was also assessed for its potential to reduce health inequalities.

LEs were considered the most effective means for providing additional preventative services in primary care and this was described as arranged under the umbrella of a generic health inequalities LE during the first phase interviews.

Public involvement was encouraged through patient involvement on planning boards as well as through stakeholder events and community conferences where public health profiles of communities were shared and views sought over strategic priorities. There was also a policy of reimbursing members of the public for their involvement in PCT meetings. The PCT had also encouraged attendance through free transport for large public events hosted by the PCT demonstrating the benefits of lifestyle changes. However, involvement in strategic decision-making was described as relatively limited.

The VCS had been involved in setting the LAA priorities and the borough strategy and there was a structured approach to representing VCS views and regular feedback from VCS participants at meetings. The VCS was widely used for providing health promotion services, especially to promote social inclusion. The LINK had only recently been established at the time of first phase interviews, but had set up a group to consider governance, a communications group and had held a public launch. There were no formal links with the LSP or with the development of the JSNA. It was considered by PCT interviewees as one but not the only route into public involvement.

Proposals were assessed for value for money by a business development group. Programme budgeting was beginning to be used and was considered useful for reassessing relative investment across prevention, treatment and rehabilitation in relation to health gain. To date, public health priorities had largely been funded through growth money.

The health scrutiny panel took an interest in the preventive agenda and was scrutinising policies to address health inequalities and diabetes care at the time of first phase interviews. Members of the health scrutiny panel also spent time going out to communities to discuss issues of concern and to promote public involvement. They also worked jointly with other scrutiny panels.

In the second phase, there had been a number of shifts in the local authority which had adversely affected aspects of partnership working across the health and well being agenda. As in other sites, it was recognised that financial stringency posed a challenge but it was emphasised that this was a challenge for the organisation as a whole and not a 'public health problem'. Everything would need to be funded through the main budget and separate monies for prevention would not be available. The JSNA was being developed along a life course model and also being used for forecasting. It was emphasised that commissioning needed to adopt a broader partnership perspective and not simply focus on the NHS. The three consortia had

reduced to two and the health inequalities LES had not been successful as it had turned out to be too complex to implement. As in other sites, there were attempts to rationalise the use of LESs. The LINK was still slow to develop and had little influence on decision-making at the time of the study.

Site seven

Site seven was an urban non-Spearhead PCT with a population of over half a million and the result of the merger of four previous PCTs. It was now co-terminous with a City Council. Health had improved and was close to the English average although inequalities within the PCT persisted and a number of areas, including mental health, teenage pregnancy, alcohol misuse and physical inactivity remained worse than average. Healthcare Commission assessments were all weak in 2006/7 but there had been great improvements and the 2008/9 CQC ratings were good for quality of commissioning services and for financial management and 'fully met' for providing services (core standards). The PCT had successfully overcome a significant budget deficit and was located in the top quartile of the WCC league table in 2009.

The organisation of the PCT reflected the commissioning cycle. Public health played an influential role and had developed innovative approaches to targeting disadvantaged communities through enhanced programmes. The DPH was a joint appointment with the Council and there was a commitment to partnership working as essential to addressing the broader determinants of health and well being. The Chief Executive was co-chair of the Health and Well Being Partnership and the DPH a member. However, as in other sites, shifting investment into public health was dependent on achieving financial balance, meeting national targets and then deploying efficiency savings from other parts of the health care system.

The JSNA was built on a well-established history of health needs assessment and a key public health function. A joint DPH and JSNA report had been developed (2008) and an audit of its impact on commissioning decisions had been requested by the OSC. The DPH report discussed commissioning in detail and clear commissioning recommendations were made for both the PCT and PBC to address the health priorities in four disease areas, five lifestyle areas and seven population groups. Locality commissioning was also considered with enhanced public health programmes directed towards addressing health needs in the most disadvantaged areas. The 2009 DPH report built on that of the previous year with commissioning recommendations for each locality. Although the LAA targets were not discussed in detail these were included in the CSP. AAACM was included as a LAA priority.

There had been a history of GP purchasing and PBC was described as making good progress with the emphasis largely on developing clinical pathways of care, rather than on developing business cases for new proposals. There were four consortia which included almost all practices, a confederation where the four consortia could come together, and a formally agreed PBC governance framework. The consortia also had named

pharmacy contacts, a named public health link and PCT non-executive directors were linked to the consortia. There were plans to include practice nurses but there was currently no structure for involving the public. PBC consortia were involved with the prioritisation process and there were also examples of the rapid spread of good practice across the consortia.

LEs were generally considered an effective way of achieving results in general practice although some scepticism was expressed over their effectiveness, as well as over the use of individual incentives for behaviour change.

Patient and public involvement was well developed in the PCT and there were examples of direct involvement in commissioning through assessing bids, for example. As well as the condition-specific planning and commissioning groups on which patients were involved, there was also an innovative patient advisory forum which had been established (with external support) to be representative of the population of the city. There was also a separate elders group, consulted by a range of organisations. Feedback on DPH reports was encouraged through the PCT website. There were a number of contracts with the VCS.

The LINK had also made good progress and a governing board and membership had been established with membership focused on individuals rather than organisations. There was an advisory group which included PCTs and NHS Trusts. While there were close links with the OSC, there were few with PBC, the LSP or with the development of the JSNA.

Prioritisation was carried out via a Board-approved process and, as in other sites, the importance of focusing on total spend was emphasised in order to get best value for money. Programme budgeting data was used for benchmarking and the financial plan summarised investment and disinvestment requirements for tackling priority areas.

In second phase interviews it emerged that partnership with the local authority had made further progress, with the local authority setting up a new public health coordinating group and establishing a new health improvement post to work on a joint agenda. Further development was needed to connect up different sectors of the community including GPs, police and education. Greater rigour had been applied to the prioritisation process within the PCT and health economics modelling was now being carried out although it was recognised that there were no easy answers to the issues raised. It was considered too complex to identify preventative health spend and there was now little scope for new investment. PBC governance had been developed further with a clearer separation of commissioner and provider functions and some health and well being initiatives were also being developed through PBC. Consultation with the public had also been developed but the LINK was considered to have a 'diffused' constituency and only one of a number of routes for engaging with the public.

The JSNA would continue to be incorporated within the DPH report. It was emphasised that greater involvement of the VCS, the public and PBC was

required so that their areas of concern could be included. In the same way, better links were needed between practices and the multi-agency work being carried out in localities. A public health governance group was now meeting on an ad hoc basis only as it was recognised that public health was integral to the work of the entire organisation.

Site eight

Site eight was an urban Spearhead site and the result of a merger of two former PCTs, serving a population of over 350,000. It was not co-terminous with the City Council. Health was worse than the English average, especially in relation to life expectancy and infant mortality. Assessments by the Healthcare Commission in 2006/7 were positive with quality of services and the new national targets rated as excellent, while the use of resources was fair. In 2008/9, quality of commissioning services was assessed as fair, financial management was good and 'providing services' was fully met. This PCT was located in the top quartile of the WCC league table.

There was a city-wide health and well being partnership but the DPH was not a joint appointment, although there were some joint roles. Public health was involved in commissioning health improvement services rather than being embedded throughout the commissioning cycle. Health and well being was given a high priority in the PCT with a particular emphasis on engaging with those already in the health care system through developing innovative and large scale approaches to the self management of long-term conditions. Engagement with local populations, linked with social marketing initiatives, was being informed through the development of detailed typologies building on geo-demographic tools, such as Mosaic. Partnerships with the local authority required further development and the lack of co-terminosity created some barriers.

The JSNA was city-wide, largely based on previous assessments and there had been extensive consultation, including a citizen's panel, and some engagement with LINKs and the VCS. However, there had been little involvement of PBC and it was argued that more ownership by GPs of the JSNA was needed. While the JSNA did not make commissioning recommendations it did identify current services in place to address needs and appeared to have improved data sharing across agencies. A separate DPH report made commissioning recommendations and emphasised the importance of partnerships. It provided details on where services were being commissioned from, including services commissioned by the PCT; services jointly commissioned with other PCTs such as the stop smoking helpline; services commissioned through the local authority, such as an 'Exercise on Prescription' service; and areas where the PCT was working in partnership with the local authority to commission services to tackle priorities. The DPH report also discussed commissioning for localities arguing that locality commissioning boards were integral to commissioning for health and well being. The subsequent JSNA, in 2009, also included locality profiles.

There were six PBC localities, each developing a three year locality commissioning development plan. These were described as working well with resources being targeted to health improvement. However there was little discussion of PBC in the CSP.

The CSP discussed incentives including the use of LESs to encourage practitioners to engage with providing services. However, interviewees noted that the number of LESs was being reduced as it was argued that they had often been used for funding mainstream services: developing innovative approaches through new contracts and specifications was considered a more fruitful route. Individual incentives for behaviour change were limited to a health and well being programme for staff, although some other initiatives were currently being piloted.

There were networks of third sector organisations and a third sector assembly established around LAA themes, with some involvement in the choice of targets. The compact was being revised at the time of first phase interviews. Strategic involvement in the commissioning process by the VCS was described as in need of development and it was argued by VCS interviewees that the PCTs and partnerships needed to become more aware of the knowledge held through the VCS, especially in relation to those in greatest need.

Setting up the LINK had been a slow process with representativeness difficult to achieve. However at the time of the interviews there was a core board and membership which could be either individual or organisation-based. At this point, there were no links with PBC but plans to engage with young people, considered a gap for the organisation.

Prioritisation was carried out through a gateway process and proposals were assessed for return on investment and strategic fit. Decommissioning and service redesign were key to the PCT delivering its strategy.

Second phase interviews demonstrated increased scepticism over the use of LESs, as they were often inadequately performance managed. It was considered important to develop different kinds of contracts but also not to depend entirely on contractual sources of motivation but to develop partnerships and greater ownership of the health and well being agenda. Influences on PCT commissioning were often derived from views of individual clinicians rather than collective views of the consortia. PEC clinical leads were appointed by the PCT with delegated authority rather than elected by PBC localities and this could lead to tensions. It was also argued that PCT functions related to primary care performance could be better integrated.

Site nine

Site nine was a non-Spearhead area and the result of the merger of two former PCTs, but was not co-terminous with the local authority. It served a population of just over 300,000. Health was generally better than the English average although there were marked health inequalities within the PCT area. The Healthcare Commission assessment was fair for both quality

of services and use of resources and 'new national targets' was rated weak, In 2008/9 quality of commissioning services was good, financial management was rated fair and 'providing services' (core standards) was fully met This PCT was located in the second quartile of the 2009 WCC league table. The PCT had moved to a more stable financial footing and health and well being had been funded primarily through growth money.

The DPH was a joint appointment. Public health and addressing health inequalities were described as being central to the PCT strategy and to achieving the aims of WCC. Public health was involved throughout the commissioning process including contract monitoring. As in other sites the structure of the organisation was shifting to reflect WCC functions and different parts of the organisation were being brought together in matrix working aligned to pathway development. Although health and well being was integral to all eight work streams, with public health represented on each, it had been decided also to keep health and well being as a separate work stream. Innovative approaches had been developed in areas such as Chlamydia screening.

The JSNA, largely council led, was an overarching document for the various PCTs falling within the County Council. It was described as a focal document which informed the agenda of both the PCT and the local authority. There had been a large consultation exercise through stakeholder events: the public was also involved in a strategic commissioning forum and in discussions over priority-setting. The steering group for the JSNA included a LINK representative. Documentary analysis showed that the DPH report made commissioning recommendations but neither the JSNA nor the DPH report considered PBC nor how the JSNA would influence commissioning in the local authority. There were no pooled budgets and joint work was described as needing development.

GPs were equally divided between PMS and GMS contracts, reflecting previous funding for PMS targeted to under-doctored areas. As in other sites, it was considered that performance management of primary care needed to be improved. Progress in PBC was consistently described as good or excellent, partly due to clinical leadership, and there was also a focus on health inequalities. There were two PBC groups described as working closely with the PCT Board, including joint meetings. They were described as involved in WCC and PCT with PBC plans described as fully aligned. There were governance arrangements in place which addressed conflicts between commissioning and provision. Pooling arrangements were in place across the clusters to allow FUR to be used for larger schemes. Unusually, FUR were made recurrent to make it easier to run and evaluate pilot schemes and this was considered a highly effective incentive. A separate innovation fund was also available. Services which had demonstrated a shift from acute to community-based services, such as the relocation of clinical services, could be mainstreamed. As in some other sites, health and well being was described as an 'earned agenda', but there were examples of PBC commissioning health and well being projects. There was little discussion in

the CSP over how PBC would contribute to the health and well being agenda.

There was a proactive approach towards LESs, seen as a successful way of securing changes in primary care. These were instigated through the public health team and included a focus on 'hard to reach' groups and addressing health inequalities. There were plans to move away from annual towards three year agreements. This PCT had developed the use of individual incentives to motivate changes in behaviour for services such as Chlamydia screening and dentistry, which had proved successful. Incentives for pregnant women to stop smoking had been less successful.

Public involvement was encouraged through a public consultation event before each PCT Board meeting and there were also patient commissioning forums.

The VCS was involved in providing services, such as mental health services, and there was a gradual shift in funding from grants to contracts. The LSP held an annual stakeholder event for the VCS to discuss what was important for the district and also to look at cross-cutting issues. Funding for the VCS to provide health and well being schemes was coordinated through the LSP, but it was argued that integrated governance around shared commissioning needed development. It was argued that the flexibility of the VCS should be better recognised along with the importance of supporting small, grassroots voluntary organisations with 'local social capital' rather than relying solely on national organisations.

The LINK spanned two local authorities and was made up of a coordinating group and five locality groups which met monthly, mirroring PCT areas. It had held a number of road show launch events. There were also themed groups and plans to develop a Youth LINK. However, the LINK was still in the process of establishing itself and making links with PCTs. In common with other sites it was proving more difficult for the LINK to engage with social services. The LINK was still developing at the time of the interviews and was not seen as a main route for involving the public.

The PCT had adopted a weighted approach to prioritisation but assessing value for money involved a complex set of skills, there was no single measure and prioritisation also needed to be carried out in partnership.

In the second phase, public health and strategy had been merged into a joint directorate, with more of a public health economic perspective, partly triggered by the financial climate. There was closer working with the local authority in relation to integrated services, prevention of duplication, developing joined up pathways and governance issues arising out of new developments such as personalised care. The local authority was represented on the strategic commissioning group and a joint QIPP event had been held to see how the PCT and the LA could work together. Accountability for delivering health and well being services was increasingly emphasised.

Methods for prioritisation were being developed through assessing 'cost per annum' benefits for patients. Programme budgeting was also being used to see where it might be possible to disinvest. It was argued that contractual levers in primary care needed to be better understood and used more effectively: health and well being services should be included as part of the contract and not separately incentivised.

Site ten

Site ten was created from a large number of former PCTs with different levels of resource and performance and the transition into a single organisation had been complex. It related to a two-tier authority. Reorganisation had resulted in a PCT with the largest population of the case study sites and a greater than average population of older people. It was a non-Spearhead area with better health than average for England. Access to services and concerns over a postcode lottery in service provision were predominant concerns, with problems accentuated by the rationalisation of services and associated transport problems. The Healthcare Commission assessments showed that use of resources and quality of services was weak while new national targets were rated good. In 2008/9, quality of commissioning was good, financial management fair and providing services partly met. This PCT was located in the last quartile of the 2009 WCC league table.

The DPH was a joint appointment with the County Council and there was synergy across both organisations in relation to the public health agenda, reflected in a joint public health report (2007/8) which also made commissioning recommendations. There was a good working relationship with the local authority, a strategic plan developed jointly with the County Council with wide consultation, jointly funded posts, joint health and social care teams and co-location of many PCT officers with the county council. However, joint commissioning and partnerships governance needed development and were currently described as parallel governance rather than integrated governance. An event had been held across agencies on governance between organisations.

The strategic direction for health and well being was described as driven by the public health team. There was concern over disparities in health status across the county and attention was being directed to targeting services. The DPH report focused on equity of service provision with benchmarking and programme budgeting information being used. It also discussed PBC, recommending that Public Health Intelligence Teams developed health profiles for practices to allow them to address local health needs. Locality-based commissioning is also considered and again the role of a Public Health Intelligence Team is highlighted in exploring issues in more depth and profiling local information to inform commissioning teams, the PCT and partner organisations. The PCT's financial commitment to improving health is described in the CSP and AOP and included: a shift of resources to improving health over the next 5 years; 0.25% of the PCT's baseline (for 08/09) being set aside for investment in health inequalities and public health (in addition to the 0.25% invested in 07/08). This investment

appeared partially reliant on growth however. Due to unexpected additional resource demands the PCT had been in financial deficit which had led to a lack of alignment between commissioning intentions and financial strategy.

The JSNA was locality-based, bringing together a wide range of information around local communities with a number of area profiles supported by smaller locality profiles. It was informed by widespread canvassing of views and feedback from local communities, the VCS and PBC and tied into locality commissioning arrangements with PBC. It had demonstrated variation across a wide range of sectors ranging from education to the availability of, and access to health services. This had resulted in some priority communities being identified in order better to target resources. Traditional health needs assessments were also being carried out in parallel with the JSNA. LAA targets were aligned as far as was possible with AOP targets.

The CSP was a joint strategy developed in partnership with the council. The CSP acknowledged the importance of partnership working and the future directions of joint plans were stated. All eleven areas of care incorporated health and well being which also formed a separate area of care. Both the CSP and AOP considered PBC and the AOP identified areas where the PBC would be specifically involved in working towards PCT priorities in reducing deaths from major diseases: heart disease; cancer; and stroke. PCT and LAA priorities were aligned, however different timelines had made it difficult to align LAA indicators and Vital Signs. AAACM was included in the LAA with the PCT and the local NHS Trust signed up as partners. In the AOP for 09/10 a single metrics set with the local council had been developed to aid alignment of performance management systems across the NHS, county council and LAA.

PBC had progressed slowly given a degree of cynicism over the process as there had been insufficient PCT funds to allow practices to reinvest savings. This meant that practices had lost interest in the scheme. However, all practices were involved in one of the ten PBC consortia (subsequently reduced to six, almost replicating the previous Primary Care Groups) some of which had their own patient panels. Consortia chairs were involved in strategic development with the PCT and there was public health involvement in the consortia with senior public health staff working at locality level. There was a view that the move to PCTs had meant that successful multi-disciplinary locality-based commissioning had been lost despite a professed aim of keeping a locality focus. Governance issues in PBC were considered difficult to resolve and there was some frustration over the imposition of central over local priorities. However, GPs had formed a social enterprise as providers with separate contracts with the PCT.

There was a county-wide consortium of VCS organisations with a set of protocols which ensured that there was feedback to the VCS after representatives attended meetings. The VCS had also been commissioned by the PCT to provide support across PBC clusters for complex care cases, befriending and supporting patients. The PCT contracted for services from the VCS mainly for drugs and alcohol services: the AOP indicated that the

role of the VCS in providing services would increase and that the PCT was also considering the role of 'healthy hospitals' and networked health advice.

There were well developed methods for public consultation and involvement was described as particularly good for children's services. Board meetings were held in public in different parts of the county and prefaced with a presentation on the local area. The PCT fed back information to those who attended the various listening events.

The LINK had been slow to get established and the transition from the former patient and public involvement forums had not proved straightforward. It was anticipated that the LINK Chair would attend the board. Representativeness was an issue; however the LINK was working with local VCS organisations.

A percentage of growth money had been ring fenced for public health priorities and ethical frameworks for decision-making had been developed. However more demanding targets in relation to access to acute care had resulted in less resources being available for preventive services.

As in other sites, in the second phase of interviews there was an emphasis on the impact of financial stringency and on demonstrating return on investment. Financial stringency made the case for investing in prevention – for both the short and the longer term – more pressing. There were also plans to develop a joint PCT/local authority strategy for public involvement. Pooled budgets were seen as an important way forward and a more effective way of pushing money upstream. Service redesign was the main focus of PBC with localities grouped around different secondary care providers to provide a critical mass for commissioning clinical services. However, their engagement with the WCC assurance process was minimal.

Appendix 4 Standards, targets and performance management

This appendix provides descriptive background for Chapter 5, summarising standards, targets and performance management systems with particular reference to health and well being. This is intended to identify the wide range of relevant standards and targets, the degree of alignment across them and changes over the period of the study.

4.1 Standards

Standards for health and well being are included as part of the following: National Service Frameworks (NSFs) (which followed the publication in 1997 of *The New NHS, modern, dependable*);¹ separate national topic-based strategies; and specific standards (assessed annually, at the time of writing, through the Annual Health Check). NICE public health guidance informs implementation of the NSFs and a number of the core standards. It also provides the framework for evidence-based interventions through its public health guidance which can also inform implementation strategies of local partnerships.

The following main areas are summarised below: NICE guidance; NSFs and national topic-based strategies; standards for better health; and world class commissioning. While WCC does not incorporate standards, information on performance against targets is made available to WCC panels.

4.1.1 NICE guidance

The Centre for Public Health Excellence at NICE develops guidance on health and well being aimed at helping health professionals, NHS organisations and others achieve improvements in areas set out in the 2004 White Paper '*Choosing Health: making healthy choices easier*'² namely: smoking and tobacco control; obesity; diet and nutrition; exercise and physical activity; alcohol; sexual health; and mental health. NICE offers two types of guidance on public health: public health intervention guidance and public health programme guidance. The former offers recommendations on activities promoting a healthy lifestyle or activities to reduce the risk of a specific disease or condition. The latter takes a broader approach through, for example, targeting specific populations, topics or areas. The guidance set by NICE gives clear standards and recommendations, based on the evidence and cost-effectiveness of interventions. To help ensure NICE public health guidance is implemented and accepted by publicly accountable bodies, the guidance is incorporated into national NHS standards. It is also related to meeting core standards C22 and C23 of the Annual Health Check (see below).

4.1.2 NSF's and national strategies

NSFs were launched in 1998 as part of a rolling programme to support improvements in service quality through providing long-term strategies for improving care. The NSF's/national strategies set national standards, identify key interventions and a time span for implementation. They are continuously updated with progress reports at variable intervals. NSF's include those for mental health;³ coronary heart disease;⁴ older people;⁵ diabetes;⁶ renal services;⁷ children, young people and maternity services;⁸ long-term conditions;⁹ and long-term neurological conditions.¹⁰ The NSF's emphasise prevention. For example, standard one of the NSF for mental health refers to promoting health and combating discrimination. The Health care Commission monitored and reviewed the implementation of standards set in NSF's, and carried out a series of improvement reviews on specific topics.

The government has also set standards and provided guidance (which includes prevention) through a number of national strategies including the following: obesity;¹¹ sexual health;¹² alcohol misuse;¹³ substance misuse;¹⁴ tobacco;¹⁵ teenage pregnancy;¹⁶ stroke;¹⁷ and cancer.¹⁸ Topic-based strategies also inform NSF's.

4.1.3 Standards for better health

Guidance on standards for better health¹⁹ implemented from April 2005, sets standards which the NHS is expected to meet. It originally set core and developmental standards for seven domains, the seventh of which is public health. The standards form a common set of requirements to ensure health services are safe and of acceptable quality and are also seen as a resource by which service providers can measure and improve performance year on year. Core standards set out the minimum level of service patients and users should expect. Developmental standards provided a framework for NHS bodies to plan the delivery of services that continued to improve in line with patient expectations. Until April 2009, the Healthcare Commission was responsible for regulating and monitoring the achievement of standards by PCTs through achievement of elements in the Annual Health Check.

In 2006, The Healthcare Commission resumed all responsibilities and functions from The Mental Health Act Commission and, in 2009, the Commission for Social Care Inspection (CSCI) merged with the Healthcare Commission to become the Care Quality Commission (CQC). Core standards relating to public health are: C22, C23 and C24 and the developmental standard was D13 (assessed for 2006/7 only). In the domain of governance, the Annual Health Check measures governance arrangements against those set out in PCTs' corporate governance framework but does not acknowledge the often complex nature of governance arrangements in commissioning for health and well being, where there are numerous organisations involved. A new assessment procedure was implemented in April 2010 by the CQC.

The Healthcare Commission and the Audit Commission²⁰ (p.51) describe the state of play: in 2007/8: 94 per cent of all health care organisations declared themselves compliant with public health core standards that applied. However for the 2006/7 assessment of the developmental standard, the largest group (55 per cent) showed fair progress. Performance against key public health targets was also patchy with 27 per cent of PCTs achieving two targets or fewer and a worse performance than in the previous year. Table 1 identifies the core and developmental standards in the domain of public health.

Table 1. Core and developmental standards for the public health domain

<p>Aim: Programmes and services are designed and delivered in collaboration with all the relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas.</p> <p>Core standards:</p> <ul style="list-style-type: none"> • C22 Health care organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by <ul style="list-style-type: none"> a) co-operating with each other and with Local Authorities and other organisations; b) ensuring that the local Director of Public Health's Annual Report informs their policies and practices; and c) making an appropriate and effective contribution to local partnership arrangements including Local Strategic Partnerships and Crime and Disorder Reduction Partnerships. • C23 Health care organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the National Service Frameworks and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections. • C24 Health care organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which could affect the provision of normal services. <p>Developmental standard: 2006/7 (no longer monitored)</p> <p>D13 Health care organisations</p> <ul style="list-style-type: none"> a) identify and act upon significant public health problems and health inequality issues, with Primary Care Trusts taking the leading role; b) implement effective programmes to improve health and reduce health inequalities; c) protect their populations from identified current and new hazards to health; and
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d) take fully into account current and emerging policies and knowledge on public health issues in the development of public health programmes, health promotion and prevention services for the public, and the commissioning and provision of services.

The Health Check for 08/09 included PSAs set as part of the 2007 Comprehensive Spending Review (CSR) (see below), as well as older targets set as part of the 2004 CSR where targets were outstanding until 2010.

4.1.4 World Class Commissioning

Following the introduction of WCC in 2007 and implementation of the first round of the commissioning assurance process²¹ PCTs are assessed against 3 areas: governance; outcomes; and competencies.

(1) Governance: refers to 'board grip' and whether the board has taken ownership of, and developed, a meaningful five year strategy, supported by a robust financial plan.

(2) Outcomes: ten outcomes are assessed. Two of the outcomes (life expectancy and health inequalities) will be measured for all PCTs with a further eight outcomes determined locally from a predetermined list of 63 outcomes with clear outcome metrics. Data used to quantify the outcomes will align with the 'Vital Signs' indicator set. Additional local targets can also be chosen.

(3) Competencies: these reflect the eleven WCC competencies.

Although the overall aim of the commissioning process is to improve health outcomes, the following list illustrates how competencies one to six are related to health and well being at the highest levels of assessment (level 4). These are examples and the full list of indicators can be found in the Commissioning Assurance Handbook.²¹

Competency 1: Reputation as 'local leader' of the NHS: 'the PCT actively participates in and leads the local health agenda'.

Competency 2: Work with community partners: 'there is clear clinical and PBC leadership in the Local Area Agreement'; 'multiple partnerships are in place across a broad range of settings to support the health and well being agenda'.

Competency 3: Engage with patients and the public: 'key stakeholders strongly agree that the PCT has proactively shaped the health opinions and aspirations of the local population'; 'proactive engagement ...is embedded in all commissioning processes'.

Competency 4: Collaborate with clinicians.

Competency 5: Manage knowledge and assess needs: 'the PCT has proactive population risk stratification to identify populations at risk and to intervene at the earliest possible point'; 'the PCT has a view of unmet needs for disadvantaged sub-groups'; 'the PCT has developed plans to match the top performers on each benchmark'.

Competency 6: Prioritise investment: 'predictive modelling to support its ability to target required intervention with precision'; 'understands the return on investment of past interventions'; 'mature programme budgets for all key priority care pathways/disease groups'; 'the PCT invests for longer term health gain and can quantify impact'.

Competency 7: Stimulate the market.

Competency 8: Promote improvement and innovation.

Competency 9: Secure procurement skills.

Competency 10: Manage the local health system and working in partnerships with providers.

Competency 11: Sound financial investments (originally assessed within the governance domain).

However, performance is assessed in relation to competencies and health outcomes. This is likely to determine the degree of commissioning autonomy accorded. The assurance system is intended to form an ongoing regulation of commissioning capabilities and enables good practice to be identified through benchmarking across commissioning organisations.

Connections were being made across WCC and other formal regulatory processes, in particular across the Audit Commission and WCC assessments of 'Use of Resources' and, more generally, across Comprehensive Area Assessments (CAAs), the CQC and the WCC assurance process. However problems, such as different assessment timetables, remained.

4.2 Targets

Over the period of the project changes in targets and performance management regimes were implemented with the aim of streamlining a profusion of targets, achieving a better alignment of performance management regimes and providing an element of local flexibility in the choice of targets. This section discusses targets, which derive from Public Service Agreements (PSAs), as set out in the 2007 CSR,²² jointly agreed targets which are reflected in LAAs and DH targets as reflected in the Annual Operating Framework for the NHS. These are discussed in turn.

4.2.1 Public Service Agreements

PSAs are the overarching performance management regime for government, reflecting key cross-departmental priorities and providing a way of holding public services to account. They are produced as part of a rolling programme with a review every three years: the Healthcare Commission and Audit Commission provide a summary²⁰ of health-related PSA targets from 1998-2007. After starting out with 600 targets, PSAs have been streamlined over time. A new round of 30 PSAs, supported by outcome focused indicators, emerged as part of the 2007 CSR for 2008/9 – 2010/11, setting out the government's priority outcomes. PSA Floor Targets, linked to the Neighbourhood Renewal Strategy, were superseded as were Local PSAs with their associated stretch targets and reward elements (although there

was some overlap adding to the performance management burden locally). In their place were local targets drawn from the new National Indicator Set (NIS) and monitored through the CAA, which replaced the Comprehensive Performance Review from April 2009.

PSAs are underpinned by a single delivery agreement shared by contributing departments and progress is measured through a number of performance indicators. PSAs 12, 18 and 19 are of particular relevance to health and well being and are reproduced below (Table 2) although all PSAs have some impact.

The national inequalities target has formed part of the PSA for 2002, 2004 and 2007. From 2003, one single target, which combined elements of previous targets, was produced: 'By 2010 reduce inequalities in health outcomes by 10 per cent as measured by infant mortality and life expectancy at birth'. For Spearhead areas (that is, the fifth of local authority areas with the worst health and deprivation) the target included reducing by at least 10 per cent the gap in life expectancy at birth and the population as a whole. As part of the 2007 CSR, the existing health inequalities target formed part of PSA Delivery Agreement 18: Promote Better Health and Well-being for All. All Age All Cause Mortality (AAACM) is used as a proxy measure for the life expectancy element of the target, although the 2010 national inequalities target, with its emphasis on narrowing the gap, also remains in force. AAACM is also reflected in the NHS Operating Framework (see Vital Signs, below) and as part of the NIS (see below) as indicator N120 in the Adult Health and Well Being block. Reducing health inequalities and increasing life expectancy are mandatory outcomes for all PCTs as part of the WCC commissioning system described above, while the remaining eight health outcomes can be chosen by PCTs from a list of options or they may choose local public health targets outside this list, according to local circumstances. There is clear alignment, therefore, across the different systems.

The Institute for Government ²³ notes that only one quarter of the PSA indicators have national targets or minimum standards attached, a 'significant reduction' implying that PSAs are no longer synonymous with target-driven approaches. The same applies to the latest round of LAAs. Encouraging partnerships is built into the structure of LAAs and PSAs and reflected in the assessment procedures.

Table 2 sets out selected PSA targets set out as part of the 2007 CSR.

Table 2. PSAs, their indicators and associated national targets set as part of the 2007 CSR

<p>PSA 12 'Improving the health and well being of children and young people'.</p> <p>Indicators:</p> <ul style="list-style-type: none"> • Prevalence of breastfeeding at 6 – 8 weeks • Percentage of pupils who have school lunches • Levels of childhood obesity with the associated national target of <i>'reducing the proportion of overweight and obese children to 2000</i>
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<p><i>levels by 2020 in the context of tackling obesity across the population'</i></p> <ul style="list-style-type: none"> • Emotional health and well being and child and adolescent mental health services (CAMHS) • Parents' experience of services for disabled children and the 'core offer'
<p>PSA 18 'Promote better health and well-being for all' [23]</p> <p>Indicators:</p> <ul style="list-style-type: none"> • All-age all-cause mortality (AAACM) rate with associated national target of <i>'By 2010, increase the average life expectancy at birth in England to 78.6 years for men and to 82.5 years for women monitored using mortality rates as a proxy'</i> • Difference in all-age all-cause mortality (AAACM) rate between England average and Spearhead areas with associated national target of <i>'Reducing health inequalities by 10% by 2010 as measured by life expectancy at birth'</i> • Smoking prevalence with associated national target of <i>'reducing adult (16 +) smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less'</i> • Proportion of people supported to live independently (all ages); Access to psychological therapies.
<p>PSA 19 'To ensure better care for all'</p> <p>Indicators:</p> <ul style="list-style-type: none"> • The self reported experience of patients/users; • NHS-reported referral- to-treatment times for admitted patients; • NHS-reported referral-to-treatment times for non-admitted patients with the associated national target of <i>'Ensuring that, by December 2008, no one waits more than 18 weeks from GP referral to the start of hospital treatment or other clinically appropriate outcome'</i>. • The percentage of women who have seen a midwife or a maternity health care professional, for health and social care assessment of needs, risks and choices by 12 completed weeks of pregnancy • Long-term conditions • GP services • Health care Associated Infection Rates - MRSA with associated national target of <i>'For MRSA the average annual number of MRSA bacteraemias for the period 2008-9 to 2010-11 should be less than half the 2003-4 figure'</i> • Healthcare Associated Infection Rated- Clostridium Difficile with associated national target of <i>'for Clostridium difficile to deliver a 30 per cent reduction in the number of cases reported in 20101-11 compared to an agreed baseline in 2007-08'</i>

4.2.2 Local area agreements and the National Indicator Set

LAAs and the JSNAs which inform their development, are a key route for PCTs and local authorities jointly to address the health and well being of their local populations. Developed through LSPs, the priorities and targets

within each LAA form the three year delivery plan of the Sustainable Community Strategy. Introduced in pilot form they were rolled out on a statutory basis in 2008 following the *Local Government and Public Involvement in Health Act* of 2007.

The 2007 CSR also announced the new NIS for local authorities and local authority partnerships. From 2008, the NIS (comprising a set of 198 indicators) has been used to monitor the performance of local authorities and partnerships. The indicator set represents a streamlining of the previous indicator set of 1200 separate targets. It measures national priority outcomes identified through the CSR which are to be delivered through local partnerships. LAAs are the delivery mechanism for these targets and are rewarded through an area based grant giving local councils more control over how to distribute the funding. There is a degree of overlap with existing reward systems.

Of the 198 indicators, around 40 relate to health, derived from outcomes expressed in PSAs applicable to health and well being (shown in Table 2). Thirty-one of these indicators fall under the categories of 'Adult Health and Wellbeing' and 'Tackling Exclusion and Promoting Equality' and of the 68 indicators under 'Children and Young People' only 9 indicators fall in the domain of 'being healthy'. Although non-health targets in other areas will impact on health, it could be argued that health and well being indicators are under-represented.

While all targets are monitored, 35 locally appropriate targets from the NIS (in addition to the 16 statutory targets for education and early years) are chosen as improvement targets within each LAA through negotiation with Government Office. Some areas may choose to supplement the 35 targets with further local targets in line with the findings of local JSNAs and to help implement the Sustainable Community Strategy, but these are not reported to, or performance managed by central government. The focus on LAAs underlines the importance of joint setting and delivery of targets and of partnership working to deliver better outcomes in both health and social care.

4.2.3 Department of Health targets

Targets for 2005-8 were set out as part of *National Standards Local Action*²⁴ but were replaced by 'Vital Signs'²⁵ from April 2008. However, commitments prior to Vital Signs were also to be met and were included in the assessments of regulators. Vital Signs involves a three tier approach with the aim of allowing local services to be delivered in a way to meet local needs. The three tiers include five national priorities which apply to all PCTs where targets are set and performance managed nationally through SHAs and DH (Tier one); 17 national priorities for local delivery (of which 12 are reflected in the NIS and can be included within LAAs), where targets are locally agreed and signed off by SHAs (Tier two) and where there is a risk-based approach to performance management; and optional local priorities chosen from a list of 34 Vital Signs (Tier three) where agreements are between PCTs and SHAs without involvement of DH.

All PCTs are expected to meet national priorities and set delivery plans, signed off by their SHA. For 2008/09, five national priorities were set: cleanliness and health care-associated infections; improving access; keeping adults and children well, improving their health and reducing health inequalities; experience, satisfaction and engagement; emergency preparedness. Keeping adults and children well, improving their health and reducing health inequalities focuses on achievement in four areas; cancer, stroke, children and maternity services. Specific targets have not been set in the framework but will instead rely on PCTs achieving PSAs and targets already set in NSFs and specific strategies such as The Cancer Reform Strategy and the National Stroke Strategy. Financial penalties apply to failing to meet certain priorities such as 18 week referral to treatment target.

When deciding local priorities (Tier three) PCTs should be able to assure their SHAs of the following.

- Relevant local priorities for health, recognised in JSNA directly inform the indicators they choose to recommend from the NIS.
- They are giving clear priority to those areas where they are most challenged.
- Their operational plan clearly sets out the proposed contribution they intend to make to their LAA.

However, there is still an expectation that even if a plan for improved performance is not chosen, performance against that indicator will not deteriorate. The operating framework for 2009/10²⁶ keeps the same priorities and tackling health inequalities is described as remaining at the centre of service delivery. In considering how the 2009/10 framework builds on the priority 'Keeping adults and children well, improving their health and reducing health inequalities', it outlines partnership working and commissioning according to local need as key, considers the four key areas of cancer, stroke, maternity and children and sets a more ambitious revised AAAC mortality rate for Spearhead areas to reduce inequalities.

Implementation of regional ten year strategies and *High Quality Care for All*²⁷ also influences priorities and development. A framework for improving the safety, effectiveness and quality of care is reflected, for example, in the new requirement for health care providers to produce annual 'quality accounts'.

The changes are designed to streamline targets and make them more locally responsive. In the operating plan for the 2008/09 it is stated that:

Throughout this CSR period, I would expect that we will be able to shift even more autonomy over local target setting towards PCTs. The work on how we measure all these vital signs and how they are regulated is still ongoing, but the underlying principles of greater local autonomy and rewarding ambition will remain constant. (p.3)

However, the relationship between PSAs the NIS, Departmental Strategic Objectives (DSOs) and Vital Signs is complex leading to various mapping

exercises. For example, the Institute for Government²³ has mapped PSAs, the NIS and DSOs

(Available at:

<http://www.instituteforgovernment.org.uk/content/26/mapping-the-national-indicators-onto-relevant-psas-and-dsos>)

and the DH has described²⁸ the links across Vital Signs, the three DSOs, the NIS and the PSAs for DH, as set out in the 2007 CSR. Thirty-one of the Department's 44 DSO indicators are best delivered through co-operation between Local Government and the NHS. Hence these indicators are within both the NIS and the Vital Signs.

Despite intentions to streamline targets a large number remain, some of which overlap. For example, while the NIS was introduced with the aim of streamlining performance management at a local level, it is argued that the new indicators are simply being added to existing measures thus increasing the burden on the system.²³ While targets interrelate, the existence of different layers, separate streams of indicators performance managed through local government and the NHS and the numbers of targets involved creates a risk that a focus on overarching cross-cutting targets becomes displaced by a focus on detailed organisation-specific targets. Moreover, it has been argued that managers are more likely to concentrate effort on the areas over which they have greatest control²⁹ which works against addressing so called 'wicked issues' such as inequalities, which are long-term problems which can only be tackled through cross-sector engagement and innovation.

References

1. Department of Health. *The new NHS: modern, dependable* Cm 3807. London: Department of Health; 1997.
2. Department of Health. *Choosing health: making healthy choices easier* Cm 6374. London: The Stationery Office; 2004.
3. Department of Health. *National service framework for mental health: modern standards and service models*. London: Department of Health; 1999.
4. Department of Health. *Coronary heart disease: national service framework for coronary heart disease - modern standards and service models*. London: Department of Health; 2000.
5. Department of Health. *National service framework for older people*. Department of Health; 2001.
6. Department of Health. *National service framework for diabetes: standards*. London: Department of Health; 2001.
7. Department of Health. *National service framework for renal services: Part one - dialysis and transplantation*. London: Department of Health; 2004.
8. Department of Health. *National service framework for children, young people and maternity services: The mental health and psychological*

wellbeing of children and young people. Department of Health; London; 2004.

9. Department of Health. *The national service framework for long-term conditions*. London: Department of Health; 2005.

10. Department of Health. *Long-term (neurological conditions) NSF*. London: Department of Health; 2005.

11. Department of Health. *Healthy weight, healthy lives. A cross government strategy for England*. London: Department of Health; 2008.

12. Department of Health. *Better prevention, better services, better sexual health - The national strategy for sexual health and HIV*. London: Department of Health; 2001.

13. Cabinet Office. *Alcohol harm reduction strategy for England*. London: Department of Health; 2004. Updated in, Department of Health. *Safe, sensible, social. The next steps in the National Alcohol Strategy*. London: Department of Health; 2007.

14. Cabinet Office. *Tackling drugs to build a better Britain: Second national plan*. 2000/2001.

15. Secretary of State for Health and the Secretaries of State for Scotland, Wales and Northern Ireland. *Smoking kills: A White Paper on tobacco*. London: The Stationery Office; 1998.

16. Department for Children, Schools and Families. *Teenage pregnancy strategy: Beyond 2010*. Department of Children Schools and Families.

17. Department of Health. *National stroke strategy*. London: Department of Health; 2007.

18. Department of Health. *Cancer reform strategy*. London: Department of Health; 2007.

19. Department of Health. *Standards for better health*. London: Department of Health; 2004.

20. Health care Commission and Audit Commission. *Are we choosing health? The impact of policy on health improvement programmes and services*. London: Commission for Health care Audit and Inspection; 2008

21. Department of Health. *Commissioning assurance handbook*. London: Department of Health; 2008.

22. HM Treasury. *2007 Pre-Budget Report and Comprehensive Spending Review*. London: The Stationery Office; 2007.

23. Gash T, Hallsworth M, Ismail S, Paun A. *Performance art: enabling better management in the public services*. London: Institute for Government; 2008.

24. Department of Health. *National standards, local action. Health and social care standards and planning framework 2005/06 – 2007/8*. London: Department of Health; 2004.

25. Department of Health (DH/NHS Finance Performance and Operations). *Operational plans 2008/09 - 2010/11. National planning guidance and "Vital Signs"*. Available at:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_082560.pdf
26. Department of Health. *The NHS in England: The operating framework for 2009/10*. London: Department of Health; 2008.
27. Department of Health. *High quality care for all: NHS next stage review final report* Cm 7432. London: Department of Health; 2008.
28. Department of Health. *Department of Health strategic framework*. 2008.
29. Wismar M, McKee M, Ernst K, Srivastava D, Busse R. *Health Targets in Europe: Learning from experience*. [European Observatory on Health Systems and Policies](#). Observatory Studies Series No 13. 2008. Available at:
<http://www.euro.who.int/Document/E91867.pdf>

Appendix 5 An assessment of prioritisation tools

5.1 Background

In considering prioritisation tools relevant for commissioners, a number of questions need to be considered:

- Which prioritisation tools are most relevant for meeting commissioning competencies and strategic aims?
- To what extent do prioritisation tools enable commissioners to meet the specific demands of WCC competencies six and eleven?
- To what extent do prioritisation tools facilitate longer term strategies for investment and disinvestment or decisions over total spend?
- What resources, skills and capacity are required to utilise the tools?

This appendix begins by summarising prioritisation tools (Table 1) and then lists criteria which arise out of the demands of competency six. A preliminary assessment of the extent to which these criteria apply to each of the prioritisation tools identified is then summarised (Table 2). It should be emphasised that this is a scoping exercise and the list is not intended to be exhaustive. However Table 2 demonstrates the range of tools available, and begins to assess the relevance of these tools for specific commissioning tasks, including longer term investment strategies. A detailed account of each of the prioritisation tools is included in a separate economics report (JM, AM, HW) carried out as part of the project.

Table 1. Overview of prioritisation tools

<p>Programme Budgeting Marginal Analysis (PBMA)</p> <ul style="list-style-type: none">• Programme Budgeting Marginal Analysis (PBMA) involves two component parts, Programme Budgeting (PB) and Marginal Analysis (MA) (described separately below). PBMA is used as a pragmatic, priority-setting aid to identify how resources are being spent prior to exploring potential changes in service provision at the margin, to maximise benefit and minimise cost.• Programme Budgeting involves identifying (i) the total resources/funds available and (ii) the services these funds are currently being spent on in order to track future expenditure in each programme area to meet agreed programme objectives.• Marginal Analysis focuses on making choices across interventions/programmes at the margins. It is used to examine the benefit gained from an additional unit of resources or benefit lost from having one unit less.

- Quadrant Analysis can be used to compare PB data, that is health outcome and expenditure data on a single cost-effectiveness type plane (higher/lower spend, higher/lower outcome) for all programme budgeting categories. YHPHO have recently developed a tool called spend and outcome tool (SPOT). It can be used to identify outlier programmes, i.e. programmes with health outcomes and/or expenditure that are substantially different from the average.

Tools to elicit choices for investment

- Conjoint analysis and discrete choice experiments are survey-based methods used to elicit the trade-offs that individuals are willing to make between different characteristics of treatments and services, to estimate the relative importance of different characteristics, to estimate whether a characteristic or attribute is important and to predict the demand for a given good or service with given characteristics.
- Paired comparison analysis is a tool for ranking or prioritising options based on preference elicitation. A series of paired choices are made e.g. programme A vs. programme B, programme B vs. programme C etc. Preferences for the paired comparisons are elicited from stakeholders, and the options are ordered from 'most often preferred' to 'least often preferred'.
- Multi-attribute problem analysis / Multi-criteria decision analysis provide a method to value and trade-off the characteristics for various programmes under comparison to establish the dominant programme.
- Population cost-impact approach is used to present the benefits and costs to a particular population of moving from current to best practice. It involves three key steps, that is (i) determining the number of events potentially preventable over a set time, (ii) for the relevant intervention(s), calculating costs to derive cost per event prevented and (iii) obtaining decision-makers' preferences for one population impact measure over another based on (a) a ranking procedure or (b) a valuation exercise. The decision-maker is asked to choose between alternative interventions for the highest ranked items.
- Scoring systems e.g. the modified Portsmouth scorecard is used alongside Delphi Consensus methods to understand the relative priorities of various, predefined options in the group. Using the scorecard, each option is scored (i.e. one score for each characteristic) and the total scores for each

option calculated. The results are presented back to the group and any updates made based on stakeholder feedback. Discussions and agreements are made as to the priorities ahead.

- NHS West Midlands tool: NHS West Midlands is in the process of introducing mandatory local tariffs for a selection of lifestyle risk management services across West Midlands. Three services were selected for tariff development from a set of eight lifestyle management services by assessing readiness for tariff development based on seven pre-identified criteria, each of which were rated high, intermediate or low.

Epidemiological modelling tools

- The Association of Public Health Observatories (APHO) Health Inequalities Intervention Tool is an on-line tool. It is used to undertake (i) gap analysis to explore the gap in life expectancy between the most deprived quintile of each local authority and a range of comparator areas (e.g. within and between PCTs); and (ii) to model the impact of four high impact interventions (i.e. smoking cessation, interventions to reduce infant mortality, treatment with hypertensives and treatment with statins) on life expectancy in the LA and the most deprived quintile of the LA selected.
- Disease prevalence modelling is an approach to estimating projected disease prevalence based on regression analysis. The website for APHO includes prevalence models on cancer, chronic kidney disease, chronic obstructive pulmonary disease, coronary heart disease, diabetes, hypertension, mental illness and stroke. Eastern Region Public Health Observatory (ERPHO) provides an example of disease prevalence modelling for coronary obstructive pulmonary disease, stroke, hypertension, and coronary heart disease and chronic kidney disease at GP practice level and for local authorities for the adult population (aged 16+ years). This tool can support prioritisation when used alongside other approaches.
- Predictive modelling is an approach to predicting service use based on regression analysis.
- The National Centre for Health Outcomes Development (NCHOD) demonstration model for CHD uses a statistical simulation technique to analyse the likely impact on costs and benefits over different time horizons, of alternative strategies for the prevention, treatment and prevention and treatment (linked pathway) of CHD.

- Quest for Quality and Improved Performance QQUIP includes analysis to analysis to explore the cost-effectiveness of current resource allocation in three selected fields of health care provision (i) improving statin prescribing in CHD, (ii) utilising intensive glucose control in type I diabetes and (iii) meeting the target of the National Suicide Prevention Strategy.
- A prioritisation exercise carried out in the USA involved a systematic review of the effectiveness, cost-effectiveness and burden of disease for 25 interventions (identified by the US Preventive Services Task Force and the Advisory Committee on Immunisation Practices).

Web-based tools

- The National Institute for Health and Clinical Excellence (NICE) public health guidance and commissioning guides provide guidance, costing templates, business cases and make recommendations for populations and individuals on activities, policies and strategies that can help prevent disease or improve health.
- [Health England Leading Prioritisation](#) tool (H.E.L.P.) is an on-line tool that can be used interactively to obtain information on the cost-effectiveness and impact on health inequalities on for 17 interventions comprising programmes related to alcohol use, mental health, obesity, smoking cessation, and sexually transmitted infections. H.E.L.P.'s prioritisation method used MCDA to identify interventions for evaluation and to select criteria against which to judge the interventions. Criteria weights were derived from a discrete choice experiment (DCE) to elicit decision makers' preferences for the criteria.
- Public Health Interventions Cost-effectiveness Database (PHICED) is an on-line, electronic database of bibliographic records which links to abstracts of economic evaluation studies (located on the NHS Economic Evaluation Database <http://www.crd.york.ac.uk>) and guidance and costing tools (located on the National Institute for Health and Clinical Excellence website <http://www.nice.org.uk/>) in the field of alcohol, obesity, physical activity and tobacco.

5.2 Competency six

Competency six is described as follows:

*'Prioritise investment of all spend in line with different financial scenarios and according to local needs, service requirements and the values of the NHS. By having a clear understanding of the needs of different sections of the local population, PCTs, with their partners, will set strategic priorities and make investment and disinvestment decisions, focused on the achievement of key clinical and other outcomes. This will include investment and disinvestment plans to achieve health gains and address areas of greatest health inequality. Three financial scenarios are considered and their impact reflected in the investment and disinvestment decisions proposed.'*¹

Table 2 assesses prioritisation tools in relation to criteria relevant to meeting competency six.

Table 2. Competency six: prioritising investment

Prioritisation tool Competency 6 criteria	PBMA	PB	MA	Quadrant analysis	CA/DCE	Paired comparison	MADM	H.E.L.P.	Population cost impact	Scorecard	W. Midlands	APHO Health Inequalities	Prevalence modelling	Predictive modelling	CHD model	QQUIP	US tool	NICE	PHICED	Real options analysis	Robustness analysis	SMP
Efficiency/value for money	Y	P	Y	Y	P	P	P	Y	Y	P	S	P	S	S	Y	Y	Y	Y	Y	Y	Y	Y
Prioritisation	Y	P	Y	Y	P	Y	Y	Y	Y	Y	Y	P	S	S	Y	Y	Y	Y	S	Y	Y	Y
Predictive modelling	N	N	N	N	N	N	N	N	Y	N	N	Y	Y	Y	N	N	N	N	N	N	N	N
Burden of illness	Y	N	Y	Y	N	N	N	Y	Y	N	N	N	Y	Y	Y	Y	Y	Y	N	N	N	N
Scenario analysis	Y	N	Y	N	N	N	N	N	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Sensitivity analysis	Y	N	Y	N	N	N	N	N	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Sub-group analysis	Y	N	Y	N	N	N	N	N	Y	N	N	Y	Y	Y	Y	N	N	Y	Y	Y	Y	Y
Programme budgeting	Y	Y	N	Y	N	N	N	Y	Y	Y	N	N	N	N	N	N	N	Y	N	N	N	Y
Productivity	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Inter-sector impacts	Y	Y	Y	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	Y
Care pathway	N	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N
Public /patient involvement	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	N	N	N	Y	N	Y	Y	Y	Y	N
Clinician involvement	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	N	Y	Y	Y	Y	N
Stakeholder involvement	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	N	Y	Y	Y	Y	N
Societal values	N	N	N	N	N	N	N	Y	Y	Y	N	Y	N	N	N	N	N	Y	Y	Y	Y	Y
Level of prioritisation	A	A	A	A	N	A	A	A	A	A	A	A	A	A	A	A	N	A	A	A	A	N
Equity	N	N	N	N	Y	Y	Y	Y	Y	Y	N	Y	N	N	N	Y	N	N	N	N	N	Y
Aids transparency	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Volume of use in UK	H	H	I	H	I	H	I	I	L	I	L	I	I	I	L	L	N	H	L	N	N	N
Ease of application/use	I	I	I	I	I	E	E	E	I	E	E	E	I	I	I	I	I	E	E	I	I	C
Data requirements	L	L	L	L	I	L	I	L	L	L	L	L	I	I	H	I	I	L	H	H	H	H
Analytical complexity	L	L	L	L	H	L	I	I	I	L	L	I	H	H	H	I	I	I	I	I	I	H
Benchmark data available	Y	Y	N	Y	N	N	N	Y	N	N	N	Y	N	N	N	N	N	N	N	N	N	N

Y=Yes, N=No; P: tool potentially helps provide information on costs and/or benefits; S: tool provides supportive / supplementary data for prioritisation

Value for money: Y=Yes; Level of prioritisation – A = All, N = National, R = region (SHA), P = PCT or PbC

Volume of use/Data requirements/analytical complexity, N=Not used, L=Low, I = Intermediate, H= High

Ease of use: E = Easy, I= Intermediate, C= Complex

5.3 Assessing tools

Prioritisation tools are described in more detail in respect of the following: (i) readiness for use; (ii) the methods used; (iii) whether they can/do follow the care pathway; (iv) whether they can/do include user involvement; (v) whether they can/do include stakeholder/clinician involvement; (vi) equity issues; (vii) feasibility and user-friendliness; and (viii) uncertainty.

5.3.1 Readiness for use

Some tools have not been implemented widely in health care (such as real options analysis) or are at early stages of development. Some, such as the National Centre for Health Outcomes Development (NCHOD) CHD demonstration model, require data input. Others are off the shelf analyses which can be re-run for context-specific results.

Tools classed as demonstration models include the following:

- NCHOD Coronary Heart Disease (CHD) demonstration model²
- US prioritisation of prevention exercise for clinical services³⁻⁷
- NHS West Midlands tool⁸
- Quest for Quality and Improved Performance (QQUIP)⁹
- National Institute for Health and Clinical Excellence (NICE) public health guidance and commissioning guides
- Public Health Interventions Cost-Effectiveness Database (PHICED)
Available at: <http://www.healthengland.org/>
- Health Inequalities Intervention tool Available at: <http://www.lho.org.uk/>. This has been applied to four interventions to date i.e. smoking cessation, interventions to reduce infant mortality, treatment with hypertensives and treatment with statins¹⁰
- ERPHO's disease prevalence models Available at: <http://www.erpho.org.uk/viewResource.aspx?id=20606&sURI=http://www.erpho.org.uk/>
- NHS South of Tyne and Wear's predictive model to estimate future acute health care demand
- The modified Portsmouth Scorecard¹¹
- Yorkshire and Humber Public Health Observatory (YHPHO) PB work including quadrant analysis (the spend and outcome tool (SPOT)).
Available at: <http://www.yhpho.org.uk/>.

Off the shelf analyses include the following:

- PBMA-based interactive atlases enable users to access the analyses for visual comparison across all PCTs and correlation with other variables such as the Index of Multiple Deprivation. The Department of Health has commissioned YHPHO to provide a PB factsheet for every PCT in England, including a quadrant analysis health outcome and expenditure comparison tool.

- The Health England Leading Prioritisation (H.E.L.P.) on-line tool can be used interactively to obtain information on the cost-effectiveness, impact on health inequalities and reach of 17 interventions (comprising programmes related to alcohol use, mental health, obesity, smoking cessation, and sexually transmitted infections). It enables the user to re-run (i) subgroup analysis of interventions and ranking of interventions using different criteria, (ii) analysis at a PCT level rather than the national level, (iii) benchmarking new intervention/s against existing intervention/s. Available at: <http://help.matrixknowledge.com/>
- The Health Inequalities Intervention tool can be used to undertake (i) gap analysis to explore the difference in life expectancy between the most deprived quintile in the particular Local Authority (LA) selected and over a range of comparators; and (ii) to model the impact of four high impact interventions (i.e. smoking cessation, interventions to reduce infant mortality, treatment with hypertensives and treatment with statins) on life expectancy in the LA and the most deprived quintile of the LA selected.
- As part of NICE's public health guidance, costing templates and business case templates are available which can be applied within a local context.

5.3.2 Prioritisation tool methods

When addressing commissioning competencies each tool might be used to help prioritise investment or to evaluate efficiency and effectiveness of spend. The prioritisation tools use different methods to rank or prioritise options, including: (1) paired comparison analysis to establish choices across or within programmes; (2) conjoint analysis and discrete choice experiments (DCE) which focus on comparing the characteristics of two or more programmes and are typically used to make within programme comparisons via survey-based tools to identify the relative importance of different characteristics and to predict demand.¹² The on-line H.E.L.P. tool used DCE to prioritise across programmes.¹³ DCE was used to weight and combine five criteria scores: (a) cost-effectiveness; (b) the proportion of the population eligible for the intervention; (c) the distribution of benefits across the population; (d) affordability; and (e) certainty to produce a ranking of each intervention.

Similarly, multi-attribute decision-making (MADM), provides a framework to elicit stakeholders' preferences in the decision-making process through defining goals, describing a set of alternative scenarios, identifying decision criteria and evaluation criteria.¹⁴⁻¹⁶

Cost-effectiveness approaches to prioritisation, such as that of NICE, use a threshold incremental cost-effectiveness ratio (ICER). Programmes are selected if the ICER is equal to or less than the willingness to pay for a Quality-Adjusted Life Year (QALY), i.e. the threshold value of around £20,000 to £30,000 per QALY. However, it is not known whether the threshold value reflects society's true willingness to pay for interventions. In its guidance on the assessment of cost-effectiveness of public health interventions, NICE suggests the subsidiary use of a cost-consequence analysis (CCA) approach. This may provide additional relevant information; for example, analysts may report multiple, non-health related outcomes. The inclusion of additional outcomes may modify decisions based solely on a

cost per QALY evaluation, and may help communicate decisions to stakeholders and the public. However, no guidance is offered on how decision makers should use CCA. Decision makers may apply their own decision-making criteria, and it is not clear that this process will be transparent, or applied systematically across interventions.¹⁷

A few of the tools that were identified incorporate predictive modelling, an approach of particular relevance to competency six. Predictive models and disease prevalence models can link burden of illness to service use¹⁸ to estimate the impact of changing needs on demand for services over time, typically based on regression analysis. The models can be used for planning and commissioning purposes to compare outcomes with estimated outcomes in the future (*ceteris paribus*). In addition, scenario analysis can be undertaken using predictive modelling, e.g. estimating outcomes in the future, under different scenarios, if services are reconfigured. The tools can also be used to undertake sub-group analysis, e.g. to compare service provision for given population need, or for undertaking health equity audits.

The Public Health Intelligence North East (PHINE) website (Available at: <http://www.phine.org.uk/>) hosted by the North East Public Health Observatory (NEPHO), includes a commissioning support unit for sharing information on predictive modelling and prioritisation as well as links to predictive modelling resources. The website includes information about a predictive model developed by NHS South of Tyne and Wear (SoTW)¹⁹ which, over a 10-year time horizon, estimated a year-on-year increase in primary care consultations, among other things, driven by an increase in the elderly population. In addition, the website includes information on disease prevalence models undertaken by Eastern Region Public Health Observatory (ERPHO),²⁰ in conjunction with Imperial College, University of London. ERPHO estimated disease prevalence for coronary obstructive pulmonary disease (COPD), stroke, hypertension, and coronary heart disease (CHD) and chronic kidney disease at GP practice level and for local authorities (LAs) for the adult population (aged 16+ years).

In the Health Inequalities Intervention tool, planned outcomes were linked to estimate the impact on life expectancy figures. This tool uses gap analysis, a form of sub-group analysis, to analyse the contribution of causes of death to the difference between the most deprived quintile of the LA and a variety of comparators (e.g. England as a whole; England's least deprived quintile; the LA as a whole) for four high impact interventions (i.e. smoking cessation, interventions to reduce infant mortality, treatment with hypertensives and treatment with statins).

In line with competency six, it would be possible to develop these tools further to explore the costs of the services being compared to reflect the impact of different financial scenarios. A few of the tools that were identified make this step.^{21, 22} Sensitivity analysis can be used to explore the robustness of findings as various parameters within the analysis change, including changes in costs.

The Quest for Quality and Improved Performance (QQUIP) team²² analysed the impact of three policies (i.e. improving prescribing statins to reduce cholesterol, using intensive glucose control to better manage Type 1 diabetes and a policy to reduce the number of suicides). The approach taken was to assess current burden of disease (BoD) and the BoD averted through use of an intervention. As part of the analysis, the monetary values of 'avoidable' deaths and gains in Quality Adjusted Life Years (QALYs) were estimated, as well as the net costs of an intervention and the gains or losses in NHS productivity (assuming a QALY gain is worth £30,000). The demonstration model for CHD mentioned above, was constructed to enable policy-makers to analyse the likely impact, on costs and benefits over different time horizons, of alternative strategies for the prevention, treatment and prevention and treatment (linked pathway) of CHD.

Competency six notes the use of programme budgeting (PB) to prioritise investment and competency eleven lists PB as a key skill. PBMA is a priority-setting aid to identify how resources are being spent prior to exploring potential changes in service provision at the margin, to maximise benefit and minimise cost. This approach appraises resource allocation within certain programmes in relation to programme objectives (programme budgeting) and assesses incremental costs and benefits of shifting resources (marginal analysis).

It can be used to inform resource use and (dis)investment decisions within and across programmes. In this system, resources are allocated in relation to their relative contributions to strategic aims and objectives and tailored in light of the law of diminishing returns. Redeployment within programme areas forms an integral part of the process. The National Programme Budget Project was set up by DH in 2002 and data has been collected for DH by PCTs since 2003. Categories are largely based on programmes of care linked to specific conditions (in particular the NSFs for which it was intended to monitor expenditure) and intended to help monitor how NHS resources are being deployed. It is therefore limited in relation to broader notions of health and well being. The Spend and Outcome Tool (SPOT) developed by the Association of Public Health Observatories is updated with expenditure data using the latest programme budgeting returns. The tool and PCT factsheets can be accessed at:

<http://www.yhpho.org.uk/resource/view.aspx?RID=49488#>

One of the categories (category 21) refers to 'healthy individuals' and spending on preventative health care. The latest programme budget information²³ shows that almost all the £1.8 billion spent on Healthy Individuals in 2008/09 went on screening and immunisation programmes.

It has also been argued that national evaluation needs to be supplemented by evaluation at local level, given different historical spending patterns and therefore different trade offs. However, a major obstacle has been adequate budgetary information.

5.3.3 Care pathways

Care pathways are intended to incorporate public health and preventative activities. While a number of the prioritisation tools could potentially assess the costs and benefits associated with alternative pathways of care, including the contribution of public health interventions, in practice there are few examples that follow such a long-term time horizon. In addition, analyses tend to be intervention-specific rather than include evaluation of the multiple interventions and services that might be accessed and used along the individual's journey and potentially over the lifetime of care.

The NCHOD demonstration model for CHD is perhaps the most advanced prioritisation tool in terms of following the patient pathway of care and in linking use of public health and acute interventions. The analyses were based on discrete-event simulation models to examine the likely impact on costs and benefits over different time horizons, of alternative strategies for the prevention, treatment and prevention and treatment (linked pathway) of CHD. The latter involves comparison between e.g. primary prevention (changing CHD risk in people without CHD) and secondary prevention (changing CHD risk in people with CHD). The modelling approach enables the user to explore an *event sequence* for each individual in the simulation, a *cohort database* which lends itself to analysis by sub-group and a *cross-sectional* database which enables the analyst to explore the health state of each member of the population at a particular point in time.

Methodologies used in NICE technology assessments could be applied to model care pathways, assessing the impact of interventions for primary and secondary prevention and curative services over the life course.

5.3.4 User involvement

PCTs have a duty to involve patients and the public in decision-making. WCC competency three states commissioners need to 'proactively seek to build continuous and meaningful engagement with the public and patients, to shape services and improve health'. The majority of prioritisation tools have the potential to enable the analyst to incorporate public and/or patient preferences. The tools may also be useful as a framework for discussion, to shape debate on prioritisation (e.g. by focusing on economic concepts like opportunity cost) and potentially to help in exposing and aligning different perspectives across potentially diverse groups of people.

Participatory budgeting can be used as part of the PB/PBMA framework to give local people a say in how resources are allocated. It directly involves local people in making decisions on spending and priorities for a defined public budget.

The ranking of services or service characteristics as part of conjoint analysis and DCE, paired comparison analysis, MADM, population-cost impact approach, the modified Portsmouth scoring card, and the NHS West Midlands tool can, but do not always, involve public and patient voices. In

practice, more could be done to include values and preferences of the public.

As well as incorporating user involvement in the prioritisation of programmes, the values of users can be incorporated in the valuation of health outcomes. For example, QALYs included in NICE cost-effectiveness evaluations incorporate societal values to measure the utility associated with different health states.²⁴ The voice of the public will only reflect societal views if values are representative of the population. Furthermore, QALYs reflect the social valuation of abstract health valuations, but not society's specific valuations of individual diseases and treatments.

5.3.5 Stakeholder involvement

Most tools could include stakeholder involvement for example through selecting interventions for analysis, criteria on which to judge the interventions and to value the criteria and to produce an overall ranking of interventions being compared.

5.3.6 Equity issues

All the choices made when using prioritisation tools have an equity impact on the distribution of health across the population. For example, analyses which incorporate QALYs assume a QALY is of equal value no matter to whom it accrues, unless the QALY is adjusted to reflect equity-relevant characteristics. However, in practice few analysts using prioritisation tools explicitly note the equity impact of alternative decisions. WCC competency six asks that *'investment and disinvestment plans address areas of greatest health inequality'*. The National Programme Budget project which includes the collection of PB data, also includes data on (i) overall spend per weighted head of population (ii) all age all cause mortality and (iii) deprivation (using the Index of Multiple Deprivation), thus providing analysts with the opportunity to explore equity issues.

In tools that incorporate QALYs (i.e. the NCHOD demonstration model for CHD, Bevan et al's QQUIP work, NICE's cost-effectiveness analyses and the QALY based analyses included on PHICED), these tend to be unweighted and therefore each additional QALY has the same weight regardless of the health status or other characteristics of the individual who gains the health benefit. More could be done to develop prioritisation tools to assess equity issues explicitly.²⁵ The Health Inequalities Intervention tool enables comparison of interventions in terms of life expectancy in a particular LA and the most deprived quintile of the LA selected.

5.3.7 Feasibility and user-friendliness

When applying prioritisation tools, a key concern is their feasibility and user-friendliness. Indicators of feasibility and user-friendliness include: volume of use of each prioritisation tool in the UK; data requirements; analytical complexity; and the availability of benchmark data. The most developed in these respects include NICE guidance, PBMA analyses and paired comparisons.

5.3.8 Uncertainty

Uncertainty is a feature of any evaluation and this should be explicitly addressed when using a prioritisation tool. There will always be a chance that the wrong option is prioritised, e.g. the chosen programme may not maximise health benefit, given the resources used. Furthermore, models that may be validated in their original context may become biased or less precise in a new setting. Thus careful analysis should identify and explore critical areas of uncertainty (e.g. using sensitivity analysis) as suggested in competency six which calls for evaluation of 'different financial scenarios'.

5.4 Conclusions

Competencies are not defined in absolute terms and therefore there is significant room for interpretation in relation to the usefulness of prioritisation tools: this is reflected in the authors' categorisations. It is important to note that no judgements are being made about the quality of the tools *per se*, rather the tables provide basic appraisal of the tools in relation to competency six. While the prioritisation tools might meet most of the requirements for competencies six and eleven, the tools need to be applied appropriately, and using relevant, unbiased data. Additionally, it is important that the correct balance of representation is used when seeking stakeholder/user involvement. In general, the tools identify the interventions to be compared and the criteria by which the interventions are to be judged, then measure and value whether and to what extent the interventions meet the criteria. This takes place within a wider context of strategic priorities identified through health needs assessment as described in Chapter 9.

References

1. Department of Health. *World class commissioning assurance handbook Year 2*. London: Department of Health; 2009.
2. Davies R, Normand C, Raftery J, Roderick P, Sanderson C, Babad H et al. *Policy analysis for coronary heart disease: a simulation model of interventions, costs and outcomes*. London: Department of Health; 2004.
3. Maciosek MV, Coffield AB, McGinnis JM, Harris JR, Caldwell MB, Teutsch SM. Methods for priority-setting among clinical preventive services. *American Journal of Preventive Medicine* 2001; 21:10-9.
4. Maciosek MV, Coffield AB, Edwards NM, Flottemesch TJ, Goodman MJ, Solberg LI. Priorities among effective clinical preventive services: results of a systematic review and analysis. *American Journal of Preventive Medicine* 2006; 31:52-61.
5. Maciosek MV, Edwards NM, Coffield AB, Flottemesch TJ, Nelson WW, Goodman MJ et al. Priorities among effective clinical preventive services: methods. *American Journal of Preventive Medicine* 2006; 31:90-6.
6. Maciosek MV, Solberg LI, Coffield AB, Edwards NM, Goodman MJ. Colorectal cancer screening: health impact and cost effectiveness. *American Journal of Preventive Medicine* 2006; 31:80-9.

7. Maciosek MV, Solberg LI, Coffield AB, Edwards NM, Goodman MJ. Influenza vaccination health impact and cost effectiveness among adults aged 50 to 64 and 65 and older. *American Journal of Preventive Medicine* 2006; 31:72-9.
8. Wyatt S. *Assessment of lifestyle risk management service: Readiness for tariff development*. Birmingham: NHS West Midlands; 2008.
9. Bevan G, Airoidi M, Morton A, Oliveira M, Smith J. *Estimating health and productivity gains in England from selected interventions*. London: The Health Foundation; 2007.
10. Malhotra N, Jacobson B. *Save to invest: Developing criteria-based commissioning for planned health care in London*. London: London Health Observatory; 2007.
11. Heller RF, Gemmell I, Wilson ECF, Fordham R, Smith RD. Using economic analyses for local priority-setting: the population cost-impact approach. *Applied Health Economics and Health Policy* 2006; 5:45-54.
12. Ryan M, Farrar S. Using conjoint analysis to elicit preferences for health care. *BMJ* 2000; 320:1530-3.
13. Matrix Knowledge Group, Bazian. *Prioritising investments in public health. Report for the Department of Health*. London: Matrix; 2008.
14. Carrin G. *Economic evaluation of health care in developing countries: theory and applications*. London: Croom Helm; 1984.
15. Keeney R, Raiffa H. *Decisions with multiple objectives: Preferences and value trade-offs*. New York: John Wiley, 1976.
16. Mann R. Multi-criteria decision analysis-a new approach to an old problem. *Pharmacoepidemiology & Drug Safety* 2007; 16.
17. Drummond M, Weatherly H, Claxton K, Cookson R, Ferguson B, Godfrey C et al. *Assessing the challenges of applying standard methods of economic evaluation*. York: Public Health Research Consortium; 2007.
18. Green S, Miles R. *The burden of disease and illness in the UK: A preliminary assessment to inform the development of UK Health Research and Development Priorities*. Oxford Health care Associates; 2008.
19. NHS South of Tyne and Wear. *Predictive modelling – the future of acute health care demand across NHS South of Tyne and Wear*; 2009.
20. Walford H. Technical briefing: *Disease prevalence modelling at practice level*. Eastern Region Public Health Observatory; 2009.
21. Davies R, Normand C, Raftery J, Roderick P, Sanderson C, Babad H et al. *Policy analysis for coronary heart disease: a simulation model of interventions, costs and outcomes*. London: Department of Health; 2004.
22. Bevan G, Airoidi M, Morton A, Oliveira M, Smith J. *Estimating health and productivity gains in England from selected interventions*. London: The Health Foundation; 2007.

23. Audit Commission. *Payment by Results data assurance framework 2008/09: Key messages from Year 2 of the national clinical coding audit programme*. London: Audit Commission; 2009.
24. Rawlins M, Culyer A. National Institute for Clinical Excellence and its value judgements. *BMJ* 2004; 329:224-7.
25. Cookson R, Drummond M, Weatherly H. Explicit incorporation of equity considerations into economic evaluation of public health interventions. *Health Economics Policy and Law* 2009; 4: 231-45.

Addendum

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The management of the SDO programme has now transferred to the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton. Although NETSCC, SDO has conducted the editorial review of this document, we had no involvement in the commissioning, and therefore may not be able to comment on the background of this document. Should you have any queries please contact sdo@southampton.ac.uk.